The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

March 5, 2014

The Health Policy Commission (HPC) is charged with developing and implementing standards of certification for Patient-Centered Medical Homes (PCMH) in the Commonwealth. The purpose of the certification process is to complement existing local and national care transformation and payment reform efforts, validate value-based care, and promote investments by payers in efficient, high-quality and cost effective primary care.

HPC PCMH Certification Pathway

The HPC, in consultation with stakeholders and in consideration of existing national standards, has developed a limited list of 45 "high-value" criteria in a progressive "Pathway" for voluntary certification of Patient-Centered Medical Homes in the Commonwealth (see attached).

- Basic PCMH Certification: a practice must successfully meet all (15) criteria across the six domains for the first level of the PCMH Pathway.
- Advanced PCMH Certification: a practice must meet all the Basic Certification criteria and a minimum of 80% (12 criteria) for the second level of the PCMH Pathway, with at least one criterion in each of the six domains.
- Optimal PCMH Certification: a practice must meet all (30) criteria for the Basic and Advanced levels, and a minimum of 80% (12 criteria) in the highest level of the PCMH Pathway, with at least one criterion in each of the six domains.

PCMH Certification Process

The HPC PCMH certification is a FREE program, using a streamlined application and transparent validation process to serve as a performance-based gateway to qualify practices for enhanced payment and assess the impact of value-based care. HPC will work with participating payers to select practices for certification. Practices seeking certification will:

a. Complete a self-assessment (readiness) tool to assess the extent to which they meet the HPC PCMH criteria in each level of the Pathway;
b. Submit an application to attest to the selected criteria in the PCMH Pathway;
c. Provide a limited set of performance data on selected clinical quality and utilization measures; and
d. Participate in an on-site validation survey in which HPC will assess the extent to which practices meet the functional capabilities of criteria in the selected level of the PCMH Pathway.

Request for Public Comment

We welcome feedback on the following questions for the proposed criteria as we proceed with final planning for the PCMH Certification Program, to be launched later this year:

1. Do the proposed criteria address expectations for patient-centered, value-based primary care?
2. Are the proposed criteria appropriately assigned to each level of the Pathway and do they reflect progressive levels of advanced primary care?
3. Are there any suggestions for additional or different high-value PCMH criteria for consideration?

Please provide your feedback on the proposed PCMH Certification criteria to the Health Policy Commission at HPC-PCMH@state.ma.us by **April 4, 2014**. In addition, we welcome the opportunity to discuss the proposed criteria at an open public forum scheduled for **March 18th from 12noon-1:30pm** at the Center for Health Information and Analysis, Daley Conference Room, 5th Floor, Two Boylston Street, Boston, MA.

HEALTH POLICY COMMISSION

PCMH Certification Program Proposed Standards

Standard (Domain)	Definition
Care coordination	Use team-based, patient-centered approach to care that includes family and caregivers, to proactively manage all aspects of preventive and chronic care, with a particular focus on patients at-risk, high risk or with complex care needs.
Enhanced access & communication	Reflect appropriate, consistent and ongoing communication between the Medical Home and the patient/family/caregiver and provide continuous access to appropriate services to manage the patient's health care needs.
Integrated clinical care management (focus on behavioral health)	Focus on patients with chronic and complex care needs, align resources with population need, emphasize community resources, and facilitate transitions across the continuum. Integrate behavioral health and substance use diagnostic and treatment considerations into comprehensive care management.
Population health management	Include capabilities for electronic searchable patient data to manage health care services, promote preventive and follow-up care, address preventive care and psycho-social needs, provide appropriate follow-up, and identify gaps in patient care.
Data systems/performance measurement	Align Meaningful Use criteria and maximize use, transmission and exchange of electronic data to support continuous improvement in the quality of the patient's experience, health outcomes, and the cost-effectiveness of services.
Resource stewardship	Commit to efficiency of care by reducing unnecessary healthcare spending, reducing waste, addressing over- and underutilization, and improving cost-effective use of health care services.

HEALTH POLICY COMMISSION

PCMH Certification Program Proposed Certification Pathway

PCMH Standards (Domain)	PCMH CERTIFICATION PATHWAY		
	Basic	**Advanced**	**Optimal**
Care coordination	• Team-based care (assigned provider and care team) • Test tracking and follow-up • Identify high-priority conditions	• Referral/specialty care tracking & follow-up • Proactively manage preventive and chronic care for empanelled patients	• Care coordination oversight
Enhanced access & communication	• Optimize timely access to appropriate services • Cultural and linguistically appropriate services • System for med refills/inquires	• Active and ongoing communication • Personalized plan of care	• Active patient engagement • Informed patient choice • Ongoing access to education and community resources
Integrated clinical care management (focus on behavioral health)	• Implement evidence-based decision support • Behavioral health/substance use disorder screening & referrals • Multi-disciplinary care planning	• Self-care support • Comprehensive health assessment/intervention (focus on behavioral health/substance use disorder • Medication management/reconciliation • Care transition management	• Comprehensive behavioral health/ substance use disorder care management • Care management for complex/high risk patients • End of life planning • Integrated community-based programs and supports
Population health management	• Availability of demographic & clinical data for population management • Empanel all patients to primary care provider/care team	• System for stratifying at-risk, high-risk, complex care patients • Use care reminders for preventive/follow-up care	• Care management pathways appropriate to patient risk status • Identify and plan care around social/environmental risk factors
Data Systems/performance measurement	• Performance data/reporting • Use certified electronic health record (EHR) • Electronic prescribing	• Measure/improve experience of care • Quality improvement training, implementation and demonstration (with patient/family involvement) • Meet Meaningful Use criteria	• Integrated and interoperable HIT • Over 50% of lab/radiology orders and results in EHR as structured data
Resource Stewardship	• Monitor practice patterns and variations in care delivery	• Baseline resource utilization data/improvement targets • Preferred use of specialty care/ancillary services-quality/cost	• Tracking over/under utilization • Access to payer data on total cost of care (TCOC) • Implement waste reduction initiative(s)

HEALTH POLICY COMMISSION

PCMH Certification Program Proposed Criteria Definitions

Care Coordination: Use team-based, patient-centered approach to care, and include family and caregivers to proactively manage all aspects of preventive and chronic care, with a particular focus on patients who are at-risk, high risk, or have complex care needs.

Basic

- **Team-based care (provider assigned, roles defined)**: Patients know who their dedicated primary care provider (PCP) and care team members are. All members of the care team have clearly defined and understood roles.
- **Test tracking and follow-up**: The practice track, follows up on, and coordinates the completion and communication of tests within the health care system and other facilities (e.g., labs, hospitals) and ensures that results are communicated to the patient.
- **Identify high-priority conditions**: The practice identifies high-priority conditions for their patient populations, including conditions (e.g., obesity) related to unhealthy behaviors or a mental health or substance use condition.

Advanced

- **Referral/specialty care tracking and follow-up**: The practice coordinates, tracks, and follows up with referrals and care performed for patients within the health care system and at other facilities (e.g., hospitals) or by specialty providers (e.g., behavioral health).
- **Proactively manage preventive and chronic care for empanelled patients**: For each patient assigned, the PCP and care team proactively assesses care needs and provides needed preventive and chronic care.

Optimal

- **Oversight for care coordination**: The practice is responsible for coordinating patient care across multiple settings, including communication with care team from other service providers or payers. This includes: training and assigning care team staff to coordinate care for individual patients; providing instructions on obtaining care and clinical advice both during and outside of office hours; obtaining tests and referral results and communicating with community organizations, health plans, facilities and specialists; and involving care team staff (and ideally patients/families) in the practice's performance evaluation and quality improvement activities.

Enhanced Access and Communication: Reflect appropriate, consistent, and ongoing communication between the Medical Home and the patient/family/caregiver and provide continuous access to appropriate services to manage the patient's health care needs.

Basic

- **Optimize timely access to the appropriate services to meet patient needs (e.g., same day appointments, access to care after hours, telephonically, electronically)**: Patients have access to appropriate routine/urgent care and clinical advice during and outside of usual office hours, as appropriate to the patient needs and preferences, with the option of enhanced

modes of care communication, including telephonic and electronic access (e.g., secure messaging via email).

- **Culturally & linguistically appropriate services (CLAS)**: The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families. These activities may include: 1) assessing the diversity of its population. Cultural factors that may be important in relation to a patient's care and treatment are not limited to race and ethnicity but may also include sexual orientation, disabilities, religious beliefs, etc.; 2) assessing the language needs of its population; and 3) providing services to patients with limited English proficiency, via bilingual clinicians or professional interpreters (in-person, telephonic, or videoconferencing).
- **System for inquiries and prescription refills**: The practice has a standardized, secure, and user-friendly system (e.g., telephonic, website, secure email) for accepting and responding to patient inquiries and requests for prescription refills in a timely manner.

Advanced

- **Active, ongoing communication across care team members**: The practice has processes in place for active and ongoing communication between the primary care team (including the patient/caregiver), specialty care (e.g., behavioral health), and acute care (e.g., emergency department) to effectively coordinate and manage patients' health care needs.
- **Personalized plan of care**: The practice develops a plan of care for each patient that incorporates individual health risks, circumstances, and values.

Optimal

- **Active patient engagement (self-efficacy)**: The 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.
- **Informed patient choice**: Patients and providers discuss information about testing and treatment options, take steps in sharing a treatment decision, and arrive at a consensus regarding the preferred treatment option, particularly for preference-sensitive conditions. Examples of preference-sensitive conditions in which shared decision-making can occur include chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, cataracts, and behavioral health conditions, among others.
- **Ongoing access to education and community resources**: The practice provides patients with information and access to educational and community resources (e.g., community agencies, afterschool programs) and coordinates (with patient permission) with those resources to exchange patient information.

Integrated Clinical Care Management (focus on BH/SA): Focus on patients with chronic and complex care needs, align resources with population need, emphasize community resources, and facilitate transitions across the continuum. Integrate behavioral health and substance use diagnostic and treatment considerations into comprehensive care management.

Basic

- **Implement evidence-based decision support**: The practice implements clinical decision support (e.g., point-of-care reminders) following evidence-based guidelines for: 1) a mental

health or substance use disorder; 2) a chronic medical condition; 3) an acute condition; 4) a condition related to unhealthy behaviors; 5) well child or adult care; and 6) overuse/appropriateness issues.

- **Behavioral health/substance use screening & referrals**: The practice assesses behavioral health and substance use status and provides or arranges for mental health/substance use services.
- **Multi-disciplinary care planning:** The practice establishes criteria and a systematic process to identify patients for multi-disciplinary care planning, in which providers from a range of disciplines work together to formulate a comprehensive care plan. Defined criteria include: 1) behavioral health; 2) high cost/utilization; 3) social/environmental determinants of health; 4) poorly controlled or complex conditions; and 5) patients identified by outside organizations (e.g., insurer, health system, ACO).

Advanced

- **Self-care support (including family/caregiver):** The practice assesses patient and family/caregiver self-management abilities and works with the patient and family/caregiver to develop a self-care plan and provide tools and resources.
- **Comprehensive health assessment/intervention (focus on behavioral health/substance use)**: The practice assesses and documents patient risk factors and conducts a periodic comprehensive health assessment which includes depression and substance use screening for adults and adolescents as well as age-appropriate screenings (e.g., pediatric developmental screenings using validated screening tools) and immunizations, dependent on the patient population served. The assessment should include a focus on behavioral health and substance use with identification of risk factors and screenings appropriate to the patient population. In addition, the practice should have in place systems for referrals to behavioral health/substance use resources for treatment and ongoing care, with practice coordination and follow-up.
- **Medication management and reconciliation**: The practice conducts a medication assessment post-hospitalization and reconciliation of all prescribed medications at each visit.
- **Care transition management**: The practice coordinates and tracks patient transitions across the care continuum, and ensures that necessary information is shared among care providers and with patients/family/caregivers when transitions occur.

Optimal

- **Comprehensive BH/SA care management**: The practice identifies mental health or substance use conditions and tracks referrals and coordinates care with mental health and substance use service providers.
- **Care management for complex/high-risk patients**: The practice identifies patients with specific conditions, including high risk or complex care needs and conditions related to health behaviors, mental health, or substance use, emphasizing pre-visit planning, assessing patient progress, and addressing barriers.
- **End of life planning**: The practice discusses treatment options and preferences for custodial care and care at the end of life with patients and family/caregivers. The practice provides to the patient/family/caregiver written documentation of the discussion and

patient/family/caregiver preferences for care and treatment options. The practice maintains this information in the patient's medical files and reviews and updates this information with the patient/family/caregiver as appropriate, taking into consideration patient age and health status.

- **Integrated community-based programs/support:** The practice partners with community-based programs and supports (e.g., community organizations, social services, other agencies) to integrate those services into the physical and behavioral healthcare that is already being provided. The practice also promotes community-based wellness programs to encourage practices and promotes 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.

Population Health Management: Include capabilities for electronic searchable patient data to manage health care services, promote preventive and follow-up care, address preventive care and psycho-social needs, provide appropriate follow-up, and identify gaps in patient care.

Basic

- **Availability of demographic & clinical data for population management**: The practice collects demographics (e.g., DOB, gender, race, ethnicity, preferred language) and clinical data (e.g., current problem list, allergies, blood pressure) to identify and manage patient populations.
- **Empanel all patients to PCP/care teams**: Assign each patient to his/her own PCP and care team with sensitivity to patient/family preference, in order to foster continuity of care.

Advanced

- **System for stratification of at-risk/high-risk/complex care patients**: The practice identifies patients with specific conditions, including at-risk, high-risk or complex care needs and conditions related to health behaviors, mental health, substance use or social/environmental considerations.
- **Use care reminders for preventive/follow-up care**: The practice identifies patients for proactive reminders and uses such reminders to promote preventive and follow-up care.

Optimal

- **Care management pathways appropriate to risk status:** To standardize care processes and reduce variability, the practice implements risk-stratified care management pathways based on evidence-based practice.
- **Identify social/environmental risk factors for population management**: The practice conducts an assessment of social and environmental risk factors of its patient population and identifies appropriate practice and community resources and referrals to best support patients' needs.

Data Systems/Performance Measurement: Align Meaningful Use criteria and maximize use, transmission, and exchange of electronic data to support continuous improvement in the quality of the patient's experience, health outcomes, and the cost-effectiveness of services.

Basic

- **Performance data/reporting:** The practice obtains performance data on clinical quality, resource use, and patient experience and shares individual provider results within the practice; and practice-level results within the practice.
- **Use certified EHR:** The practice uses certified electronic health record (EHR) technology that offers the necessary technological capability, functionality, and security to meet MU criteria as well as ensure data and information security and ability to work with other systems to share information without compromising patient privacy or protected health information. Providers should have ongoing training and support in use of the EHR. EHR hardware should be replaced as needed and software should be regularly updated.
- **Electronic prescribing**: The practice is able to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care.

Advanced

- **Measure/improve experience of care**: The practice collects and uses patient/family/caregiver experience data (i.e., access, communication, coordination, self-management, support, whole person orientation, comprehensive care delivery, shared decision-making) to continuously improve services.
- **Quality Improvement – training, implementation & demonstration (with patient/family/caregiver involvement)**: Training the practice has a clear and ongoing quality improvement strategy and process that includes regular review and evaluation of performance data as well as providing practice staff with necessary training to implement and assess quality improvement initiatives. Implementation The practice utilizes an ongoing quality improvement process to set goals and act to improve performance on clinical quality, utilization and patient experience measures, addressing at least one disparity in care or service provision for vulnerable populations, and involving patients/family/caregivers in quality improvement teams or the practice's patient/family advisory council. Demonstration The practice demonstrates continuous quality improvement (CQI) by measuring the effectiveness of actions taken (e.g., by tracking
  results over time and assessing the effect of actions) to improve clinical quality, utilization and patient experience measures and achieving improved performance on at least 2 clinical quality measures, 1 utilization or care coordination measure, and at least 1 patient experience measure.
- **Meet Meaningful Use (MU) criteria**: The practice demonstrates that Stage I/Stage II Meaningful Use criteria of certified electronic health records are being met (as appropriate to practice type/setting).

Optimal

- **Integrated and interoperable Heath Information Technology (HIT)**: The practice integrates HIT into the practice in order to collect, store, manage, and exchange relevant

personal health information, with the capability for information transmission and exchange with health system partners and referral organizations.

- **Over 50% of lab/radiology orders in EMR as structured data**: The practice has the capability to record over 50% of its lab and radiology orders and test results in its electronic medical record (EMR) as structured data.

Resource Stewardship: Commit to efficiency of care by reducing unnecessary healthcare spending, reducing waste, addressing over- and under-utilization, and improving cost-effective use of health care services.

Basic

- **Monitor practice patterns & variations in care delivery**: The practice monitors variation in evidence-based practice and population health management and utilizes that information to standardize processes and improve outcomes.

Advanced

- **Baseline resource utilization data & improvement targets**: The practice collects baseline resource utilization data on acute care visits, ED visits and hospitalizations and sets improvement targets for reductions in acute care services.
- **Preferred use of specialty care/ancillary services-quality and cost**: The practice measures how well it tracks and coordinates use of specialty care by monitoring data that captures a relevant process or outcome. This should include measures related to care coordination as well as utilization measures affecting health care costs. Measures may be associated with tracking and referral activities (e.g., the frequency with which the practice provides a clear clinical reason for the referral).

Optimal

- **Track over- and under-utilization of services**: The practice monitors over-utilization of high cost clinical services (e.g. emergency department visits, MRI testing, etc.) and underutilization of appropriate services (e.g. age-appropriate immunizations and implementation of effective preventive care guidelines) through a quality improvement strategy and process that includes regular review and evaluation of performance data as well as HEDIS results and external quality reporting data.
- **Access to payer data on the total cost of care (TCOC)**: The practice is able to access and utilize timely payer data on total cost of care and healthcare utilization.
- **Implement waste reduction initiative(s)**: The practice measures or receives data on utilization affecting health care costs and demonstrates improvement on these measures (e.g. emergency department visits, hospital admissions/readmissions). The practice focuses on issues of appropriateness and overuse of treatment/care (e.g., by implementing the American Board of Internal Medicine Foundation's Choosing Wisely Initiative).