

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

April 4, 2014

Dear Members of the Health Policy Commission,

The Massachusetts Child Health Quality Coalition (CHQC) is pleased to submit comments on the recently proposed standards for certification as a PCMH (Patient Centered Medical Home) in the Commonwealth. The CHQC is the neutral convener for a broad set of stakeholders who are developing a shared understanding of pediatric health care quality priorities across Massachusetts. Members include primary care and specialist providers, parent and family advocates, hospitals, health plans, health professional groups, state and local agencies, community organizations, and policy experts. Over the past several years, one area of focus for the CHQC has been spreading the adoption of Family and Patient Centered Medical Home (F/PCMH) practices in Massachusetts.

We wish to comment from the perspective of our mission to improve pediatric health and specifically address your request for feedback on how the proposed standards meet expectations for patient centered and value based primary care.

- We agree with your statements in the request for public comments that the availability of standards for PCMH practices is a key component of improving health for Massachusetts citizens and the care delivered in the Commonwealth. The PCMH standards can inform the other components of system transformation, such as accountability and standards for specialty care and integrated care models. Specifically, the integration strategies for care provided across the community are critical for optimizing patient experience and health outcomes. The relationship of primary care to other specialty and community based care may be implicit in your proposed standards and pathway. We encourage the Commission to include explicit recognition in the standards and implementation. The inclusion of school based nurses and providers is particularly significant for children.
- The proposed standards incorporate many of the key principles learned from local and national efforts to promote PCMH in primary care practices. We applaud the inclusion of standards that address patient and family involvement, a crucial element of care that has been consistently identified in early PCMH's and the recent CHIPRA demonstration for pediatric patients and their families.
- We are pleased to see that you have identified behavioral health needs in the standards for Integrated Clinical Care Management. Patient and family involvement in the development of care plans and in care coordination is particularly important to children with special health care needs, including behavioral health issues.
- In the Integrated Clinical Care Management domain, you highlight the need for end-of-life planning and care transition management, presumably focused on transitions between sites of care. We recommend explicitly including the key transition from pediatric to adult care. This is an important and challenging transition for youth, particularly those with special health care needs; it requires action by both pediatric and adult practices.

We understand that the standards are framed at a relatively high level and will be defined further as practices participate in your proposed pilots. The CHQC and our members are committed to assisting and supporting you in this effort, providing support and feedback related to children's health. The inclusion of pediatric practices in the pilots will be essential for understanding the implementation issues unique to this specialty and these patients.

The CHQC and our work groups include families, payers, school nurses, and advocates as well as providers. This broad set of perspectives has been instrumental in developing mechanisms to pursue care integration with payers and providers, with a particularly strong contribution from family partners. We believe this perspective will be valuable as you finalize PCMH standards. Examples of the support we can provide include the following.

- CHQC's workgroup on Care Coordination has developed a framework for care coordination that is currently being tested. We believe that the framework offers ambulatory practices a helpful way to think about implementing care coordination activities. While the framework is focused on children and their caregivers, we believe that much of the work is applicable for patients of all ages and their caregivers. The Care Coordination framework specifically addresses the transition between pediatric and adult practices and elements for "personalized plan of care.
- The work of the Medical Home Learning Collaborative, that is tightly aligned with the CHQC and funded through the same CMS grant, has led to the development of resources for pediatric medical home transformation that can support pediatric practices as they adopt the HPC standards.

Finally, we would like to acknowledge your efforts to align Massachusetts standards with the national NCQA standards for PCMH. During the public meeting we heard many comments on the value in aligning with national program standards to minimize the duplication and compliance burden on providers. The newly released standards for 2014 have important changes for care management, population health, and alignment with the Meaningful Use standards. We fully support efforts to optimize the alignment in a manner that encourages a focus on improvement and minimizes duplicative efforts.

Thank you for the opportunity to participate in this important policy development effort. We look forward to supporting the Commonwealth's efforts to advance the adoption of PCMH in Massachusetts.

Sincerely,



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