

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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Person-Centered Care Planning for Persons (PCCP4P) with Multiple Chronic Conditions (MCC) Current State and Future Directions

June 9th, 2025

OHSU

Contract # 75Q80120D00019/75Q80124F32002



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OHSU

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Disclosures

This presentation is based on research conducted --- under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract No. 75Q80120D00019/75Q80124F32002). The findings and conclusions in this presentation are those of the authors, who are responsible for its contents; the findings and conclusions do not necessarily represent the views of AHRQ. Therefore, no statement in this presentation should be construed as an official position of AHRQ or of the U.S. Department of Health and Human Services.

Agenda

1. Introduction

- Introduction to the PCCP4P Project (Ana Quiñones)
- Caring for People with Multiple Chronic Conditions (Arlene Bierman)

2. Why Person-Centered Care Planning Matters: Perspective from Funders

- Age Friendly Health Systems and the 4 Ms: The John A. Hartford Foundation (Cheryl Phillips)
- Patient Centered Outcomes Research Institute (Erin Holve)

3. Example of Strategies in Practice: Patient Priorities Care (Aanand Naik)

4. Main Findings from March Summit and Reports (David Dorr)

5. Panel & Audience Discussion

6. Future Directions & Summary (David Dorr)

7. Questions



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Introduction to Person-Centered Care Planning for Persons with Multiple Chronic Conditions (PCCP4P)

Ana Quiñones, PhD, MS

PCCP4P Co-Director

Professor

Oregon Health & Science University

OHSU

Background

- People living with MCC often navigate a complicated and fragmented healthcare system, receiving care from multiple providers across multiple health systems and practices
- Fragmented care is inefficient, duplicative, costly, risky, and unduly burdens people living with MCC, their families, and caregivers
- People living with MCC may also have unmet needs that further impact their health and well-being

Objectives

Project Objectives

1. Understand the current state of the field for Person-Centered Care Planning (PCCP) for people living with multiple chronic conditions (MCC), including innovative and successful PCCP approaches and models as well as gaps in our knowledge.

2. Understand reported barriers, facilitators, and necessary conditions for implementation of PCCP identified by policymakers, health system leaders, front-line providers, researchers, people living with MCC, and their caregivers.

Project Outcomes

- **Develop an action plan to facilitate the scale and spread of person-centered care planning for people living with MCC across diverse health systems and settings.**
  - Developed with active engagement from experts, partners, practitioners, frontline implementers, researchers, and persons with MCC, their families, and caregivers.

- **Information gathered through such engagement will provide foundational knowledge to enable AHRQ's larger, long-term goal of promoting person-centered care planning as standard practice for people living with MCC.**

AHRQ's Definition of Person-Centered Care Planning

It is a process of active collaboration and shared decision-making that incorporates patients' goals of care and fits into the person's life context.

It is characterized by team-based collaboration among clinicians, patients, and patients' broader care networks.

The aim is to coordinate the identification, treatment, and management of biomedical, behavioral, and social determinants of health for people at risk for or living with multiple chronic conditions including those with complex care needs.

Patients engage in shared decision-making with clinicians and other care team members to develop an individualized care plan that aligns with their preferences and goals to optimize health, well-being and functioning.

The care plan follows a person, when needed, across different providers and settings of care, allowing for care team coordination.

PCCP4P Task Order Goals

Project Timeline: January 2024 – July 2025, Project includes 8 tasks

Task	Description	Deliverables
1. Technical Expert Panel	8-12 member panel to help guide work	18 experts gave input on Scans, Partner Roundtable, Learning Collaborative, and Summit
2. Environmental Scan	Develop 1 baseline scan on the state of PCCP for people with MCC and 2 ad hoc scans (TBD), utilizing key informant interviews	Found 40 published models of PCCP for people with MCC, reviewed connections between CBOs and PCCP, investigated measures of PCCP
3. Partner Roundtable	Engage 25-30 health system leaders, policy makers, PCCP decision makers over 4 to 6-hour sessions	Gathered 56 partners over four 4-hour meetings to discuss key leverage points for PCCP scale and spread
4. Learning Collaborative	Recruit 25-30 front-line practitioners, implementers, real-world users in half-day sessions to understand implementation challenges and facilitators	Convened 48 frontline participants over six 3-hour sessions to exchange knowledge, identify barriers and facilitators, and synthesize best practices
5. Summit	Convene all task participants to develop an Action Plan for scaling and spreading PCCP for people with MCC	Convened 84 participants in Rockville, MD March 3, 2025 with 31 virtual attendees. Summarizing strategies and findings from rich conversations.
6. Project Report	Summary report of findings from all tasks	One final report summarizing all findings is in development.
7. Dissemination	Deliver webinars, manuscripts, and other products	Presented symposium at GSA 2024, conducted 2/3 public webinars, developing 3 manuscripts
8. Project Management	Coordinates deliverables with task teams and AHRQ	Coordinated all tasks, met weekly with Task Order Officer, compiled monthly Quarterly Reports



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Caring for People with Multiple Chronic Conditions

Arlene Bierman, M.D., M.S.

Health Systems Transformation
Improving Care for People at Risk for or Living with Multiple Chronic Conditions

- **Healthcare in the U.S. falls short** of achieving the objectives of improving individual and population health
- Our health system **is ill-designed** to foster active/health aging –
  - ► **Disease focused rather than person-centered**
  - ► **Focused on illness rather than wellness**
- **Quality is suboptimal** and care is fragmented, difficult to navigate, and burdensome
- The cost of **waste** in the healthcare system has been estimated to ranged from **$760 billion to $935 billion,** accounting for approximately 25% of total healthcare spending
- Economic analyses have found that a slowdown in aging that increases healthy life expectancy by 1 year is **worth $38 trillion over one year**, **and $367 trillion over 10 years**
- **Clinician burnout** is a major problem and there **opportunity to improve both clinician and patient experience**

The Challenge of Multiple Chronic Conditions (MCC)

- **Disease-specific vs. person-centered approaches.** Disease-specific approach to care delivery and research is misaligned with the **whole person-centered needs** of patients and caregivers.
- **Interoperability obstacles in complex care.** People with MCC require care in multiple settings, from multiple providers. **Data do not easily move across settings of care**.

People with MCC account for:

64%	70%	83%	71%	93%
OF ALL **Clinician Visits**	OF ALL **In-Patient Stays**	OF ALL **Prescriptions**	OF ALL **Healthcare Spending**	OF ALL **Medicare Spending**

NEARLY

1 IN 3 American Adults & **4 IN 5** Medicare Beneficiaries

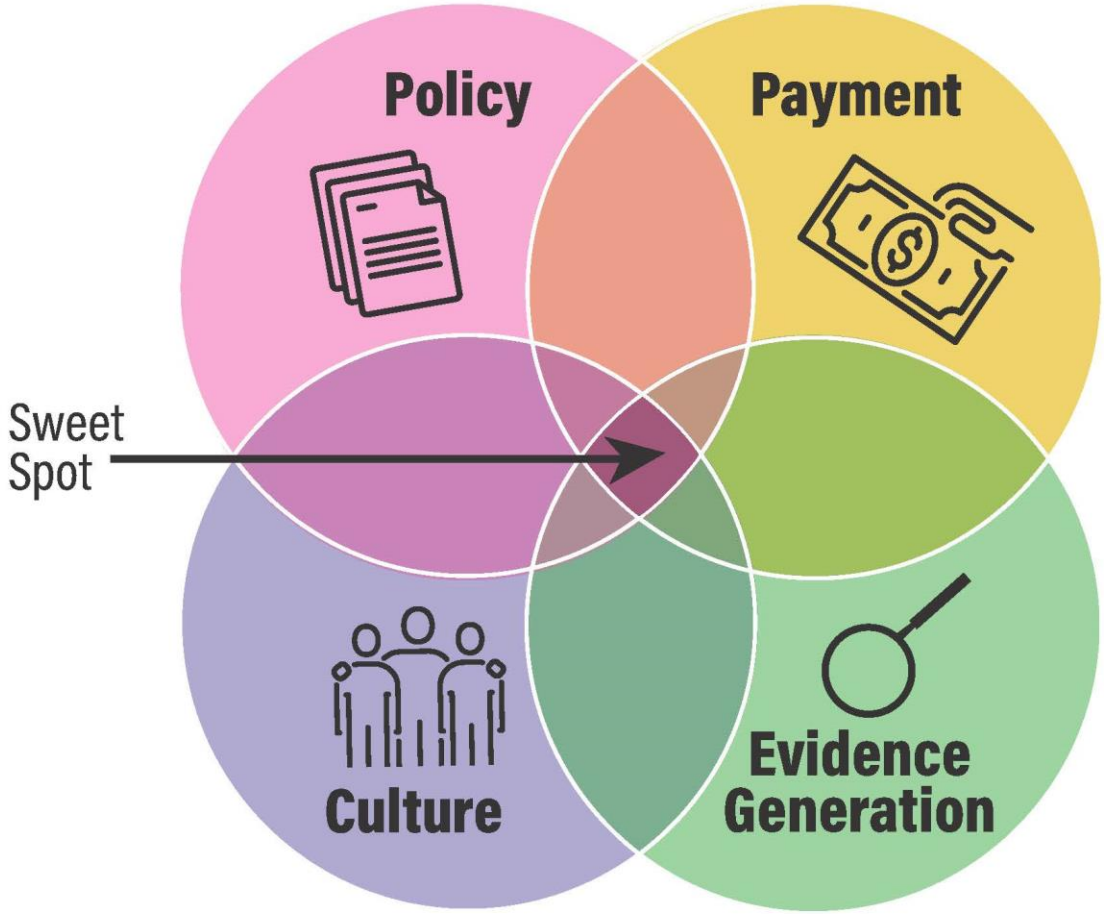
ARE LIVING WITH MCC, THE **MOST COMMON CHRONIC CONDITION**

CMS 2018: *https://www.cms.gov/data-research/statistics-trends-and-reports/chronic-conditions/chartbook-and-charts*;
AHRQ 2010: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf;
Quiñones, et al. Racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults. *PLoS One*, 2019;14(6), PMID: 31206556.

A Collective Failure to Act
Multiple Reasons

- Nihilism
- Agism
- Avoidance and Denial
- Lack of Awareness of Existing Evidence
- Competing Priorities
- Misaligned Financial Incentives
- Concerns about Cost

Health System Transformation and Aging Well
The "Sweet Spot"



Defining Person-Centered Care

"Person-centered care" means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires."

"Person-Centered Care: A Definition and Essential Elements" The American Geriatrics Society Expert Panel on Person-Centered Care, December 2015 https://www.ncbi.nlm.nih.gov/pubmed/26626262

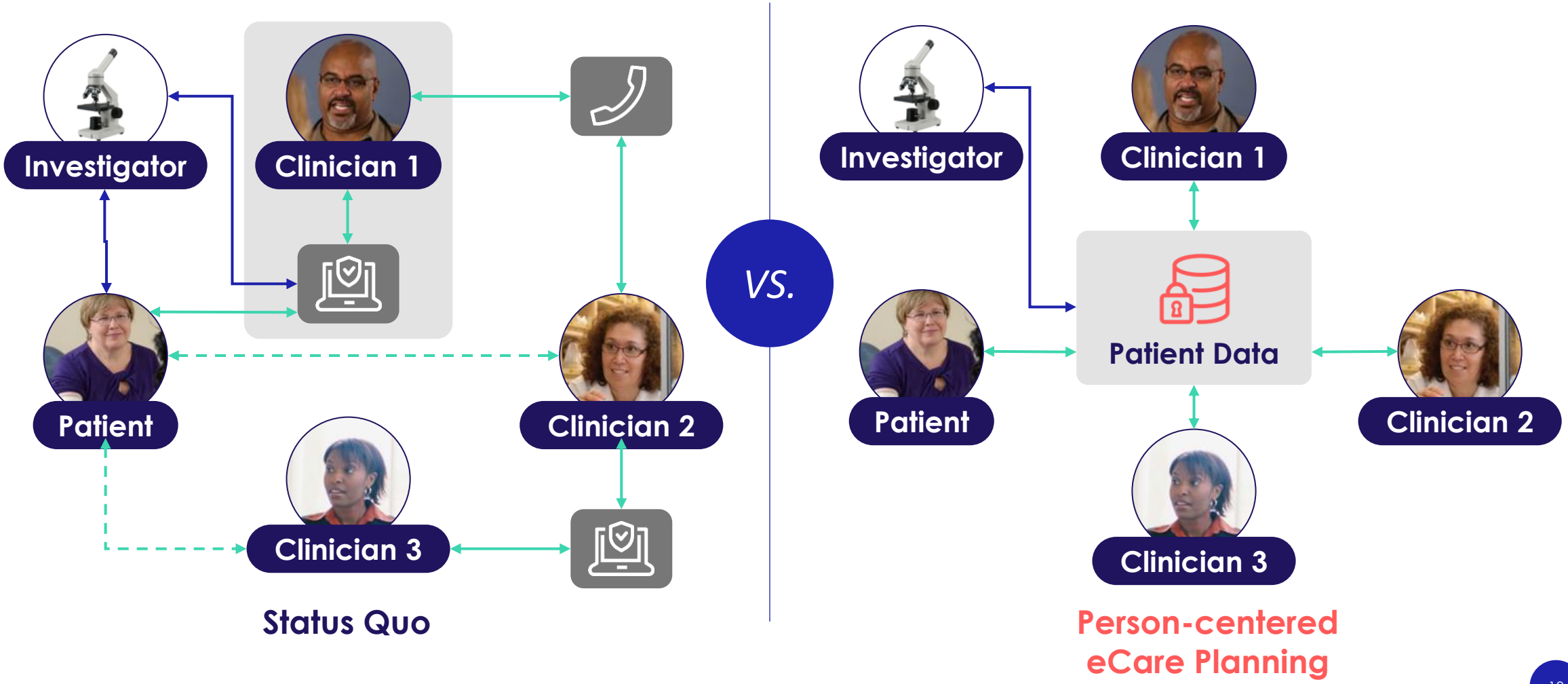
Person-Centered Care Planning for People Living With or at Risk for Multiple Chronic Conditions

Nine Themes

- Sub-optimal quality of care
- Person-centered, goal-concordant care
- Multidisciplinary team-based care and care coordination
- Prevention across the life course
- Digital health solutions
- Workflow
- Education and self-management support
- Payment
- Achieving community, health system, and payer goals

Person-Centered Care Planning for People Living With or at Risk for Multiple Chronic Conditions | Health Policy | JAMA Network Open | JAMA Network

Comprehensive Standards-Based eCare Planning

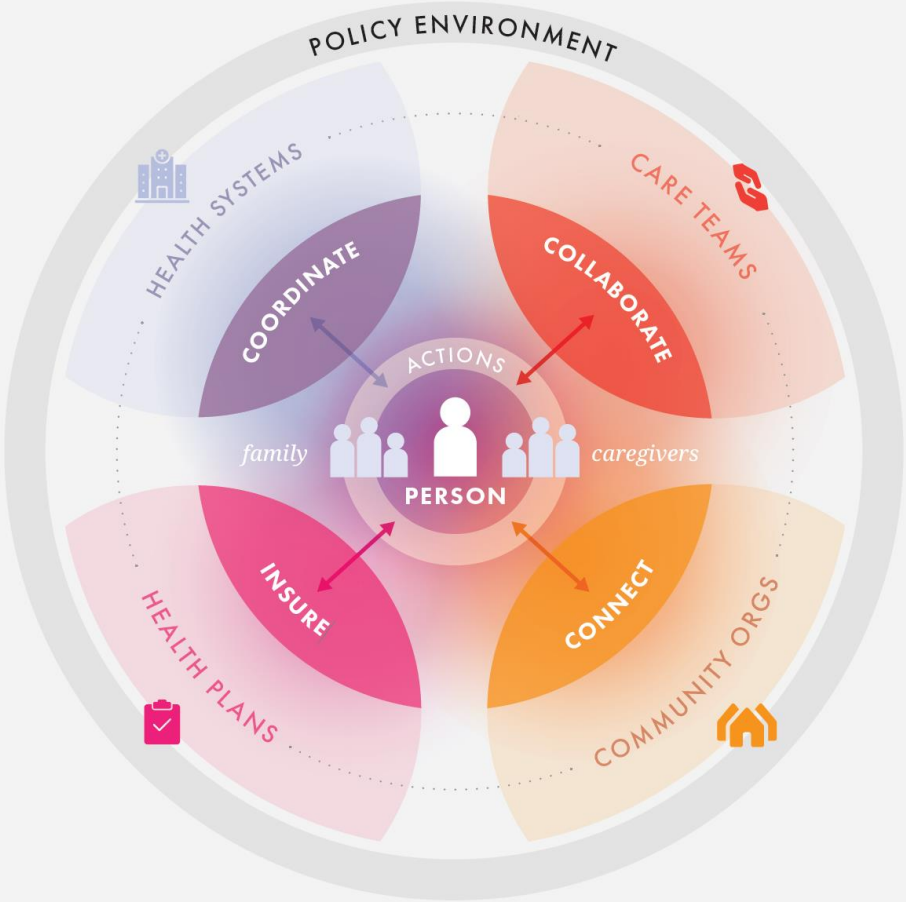


Status Quo

Person-centered eCare Planning

U.S. Department of Health and Human Services 2015 stakeholder panel

PERSON-CENTERED CARE PLANNING MODEL



PERSON-CENTERED ACTIONS

HEALTH SYSTEMS ▸ PERSON

Coordinate across providers and care settings

COMMUNITY ORGS ▸ PERSON

Connect with community resources and services

CARE TEAMS ▸ PERSON

Collaborate on individualized care plans

HEALTH PLANS ▸ PERSON

Insure with comprehensive coverage

ENTITY INTERACTIONS AND WORKFLOWS

Entities work together in a coordinated fashion facilitated by the policy environment to provide high-quality PCCP.

Pieces of the Puzzle

Putting it All Together



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Why Person-Centered Care Planning Matters: Perspectives from Funders

The John A. Hartford Foundation

Agency for Healthcare Research and Quality

Person Centered Care Planning for People with MCC - Current State and Future Directions Webinar

June 9, 2025

Cheryl Phillips, MD, AGSF

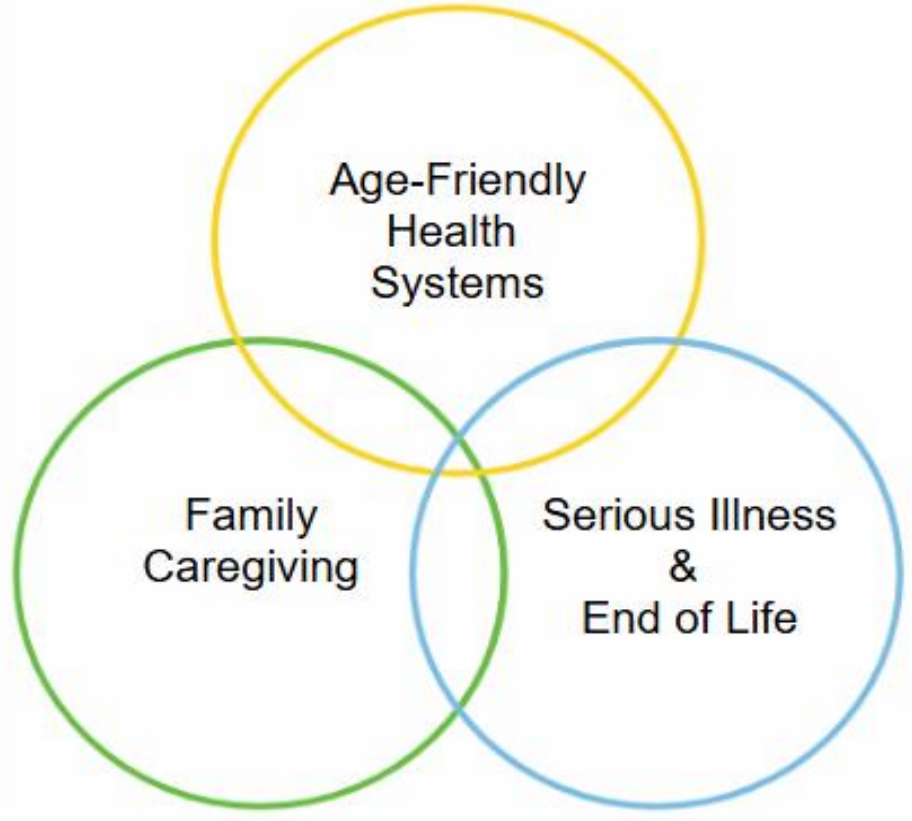
Senior Program Consultant

The John A. Hartford Foundation

Mission

DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

PRIORITY AREAS

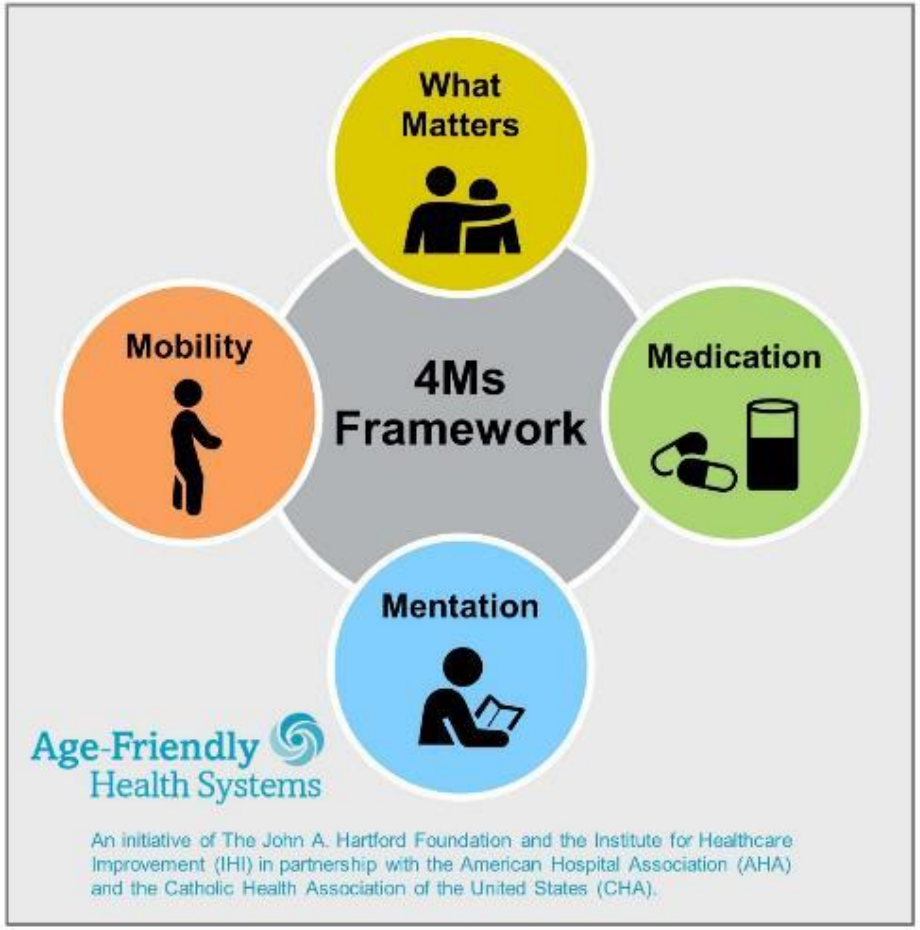


Age-Friendly Health Systems: Aim

The John A. Hartford Foundation

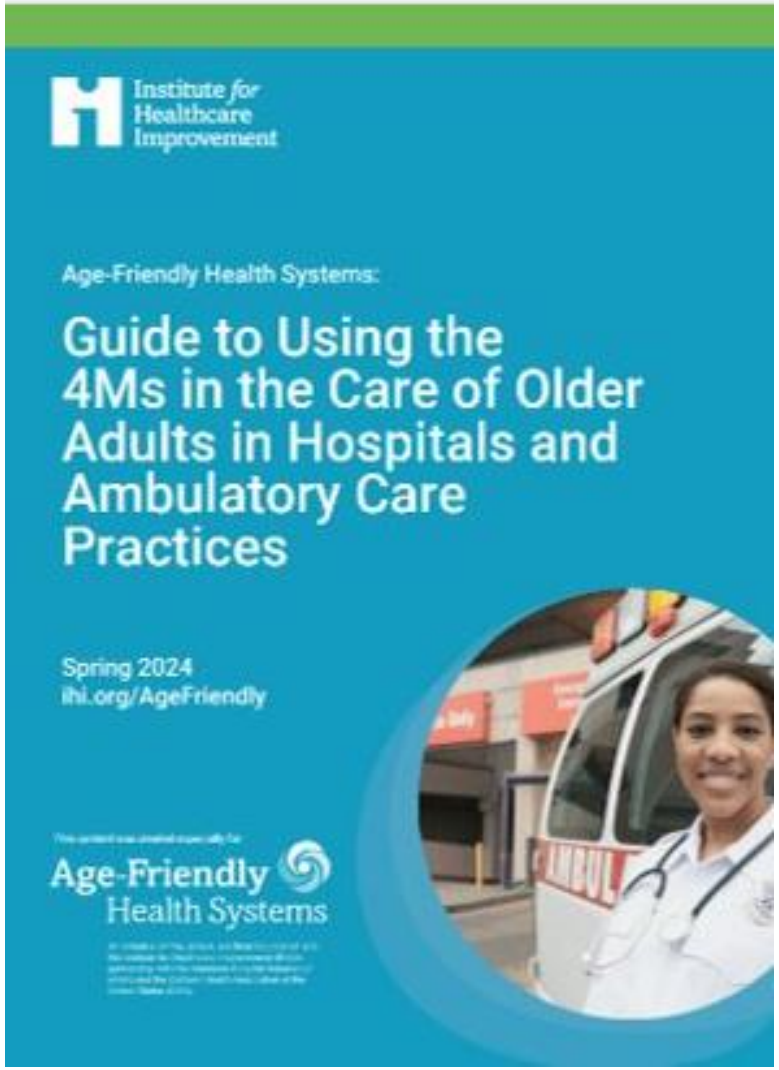
Build a movement so ***all care*** with older adults is equitable and **age-friendly**:

- Guided by an essential set of evidence-based practices (4Ms)
- Causes no harm
- Is consistent with *What Matters* to the older adult and their family



www.ihi.org/agefriendly

Fulmer, T., Mate, K. S., & Berman, A. (2018). The age-friendly health system imperative. *Journal of the American Geriatrics Society*, *66*(1), 22-24.



Guide to the 4Ms

The John A. Hartford Foundation

- IHI resource guide to help hospital and ambulatory practice care teams test and implement the 4Ms
- Key actions for the implementation of Age-Friendly Care
- How to measure the impact of using 4Ms Age-Friendly Care
- Other free resources available on EHR integration, business case, system-wide spread and more

ihi.org/age-friendly-health-systems-resources-and-news

CMS Age-Friendly Hospital Measure – Built on the 4Ms of Age-Friendly Care

The John A. Hartford Foundation

- FY2025 Hospital Inpatient Quality Reporting Program (pay-for-reporting)
- Participating hospitals required to report on:
  - **Eliciting Patient Healthcare Goals (what Matters)**
  - **Managing (Medication)**
  - **Implementing Frailty Screening (Mentation & Mobility)**
  - **Assessing Social Vulnerability**
  - **Designating Age-Friendly Care Leaders**
- Data will be public on Medicare Care Compare
- Age-Friendly Health Systems and related initiatives help hospitals meet measure
- CMS is accepting public comments. Submit by **June 10.** Please refer to **file code CMS-1833-P**: bit.ly/CMSHospitalMeasureComment

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

bit.ly/CMS_AFMeasure

UCSF AFHS Research Network

The John A. Hartford Foundation

- Collaboration, networking, resource sharing among AFHS researchers
- Mission to advance the evidence base for AFHS and the 4Ms
- Welcomes members from all disciplines, ranks & settings
- Join the AFHS Research Network today! Visit **bit.ly/AFHS_ResearchNetwork**

Person-Centered Age-Friendly Care is What We All Want

The John A. Hartford Foundation

Person-Centered Care Planning =

Asking and Acting on **What Matters**

Thank you to the Agency for Healthcare Research and Quality for all your work

The John A. Hartford Foundation

Thank You!

Cheryl.Phillips@jonahartford.org

WWW.JOHNAHARTFORD.ORG

DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS



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Patient Centered Outcomes Research Institute

Erin Holve, PhD, MPP, MPH

Chief Officer for Research Infrastructure and Innovation

Patient Centered Outcomes Research Institute

PCORI Funding Opportunities

- Cycle 3 2025 - seven funding opportunities in patient-centered comparative clinical effectiveness research (CER), methods for CER research and dissemination & implementation
- Open August 12th, 2025
- LOIs due Sep. 23, 2025

Join the Applicant Town Hall. Aug. 18, 2025, 11:30 am (ET)



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Example of Strategies in Practice

Person-centered care planning for people living with multiple chronic conditions

patient priorities care
Age-Friendly Health Systems

Framework for Identifying and Aligning Care with What Matters Most

Aanand D. Naik, MD

Professor & Nancy P. and Vincent F. Guinee, MD Distinguished Chair;

University of Texas Health Houston

June 6, 2025

Widowed, retired lives in his daughter's home for 10 years

Dx: T2DM, HTN, HFpEF, PVD, anemia, CRI class 2, CAD s/p stent, chronic lumbar pain

Meet Mr. JW, 79 y/o

- **Cardiologist:** Heart failure & hypertension (add Entresto and Aldactone; echo and stress test)
- **Endocrinologist:** Diabetes (↑ Metformin, add Tresiba)
- **Ophthalmologist:** Retinopathy (intra-ocular therapy)
- **Vascular Surgery**: PVD (angiogram Rt peroneal artery lesion, Plavix)
- **Orthopedics:** Lumbar radiculopathy (MRI, PT, pain meds)
- **Emergency Department:** Rectal bleeding (diverticulosis)
- **Primary Care:** 15-20 min visits; BP, Lipid & DM metrics
- **New presentation:** Fatigue, weakness, elevated K+ / Cr
  - 12 active medications
  - 13 doctor visits in 6 months

patient priorities care
Age-Friendly Health Systems

Care for Older Adults with Multiple Conditions

Unintentional harm

- 1 in 3 older adults with MCCs receive guideline-recommended drug harms a coexisting condition*
- 10% adverse drug reactions**

Burdensome

- 2 hours per day on healthcare tasks
- ½ day per health encounter (office visits, diagnostic testing, procedure)

*Lorgunpai, PLOS One, 2014
**Gandhi, NEJM 2013

patient priorities care
Age-Friendly Health Systems

Patient Priorities-Aligned Care

Identify Health Priorities

- Value-based (What Matters Most to the patient)
- Specific, actionable and realistic outcome goals
- Current care patient finds helpful or burdensome
- The One Thing (Top Priority): Health problem patient most wants to address to achieve their outcome goal

Align Care with Health Priorities

- Consider all factors (e.g., clinical, social) interfering with patient's health priorities
- Consider interventions to start, stop, or continue based on these factors
- Use patient's priorities as focus of communication and decision-making with patients, care partners and other health professionals

Update as needed

patient priorities care

Mr. JW's identified health priorities

- **Matters Most:** Stay active to keep up ministry duties. Enjoys riding bicycle. Time with daughter's family. Quality of life more important.
- **Outcome Goals**: Ride my bicycle 1-2 miles every few days. Walk around church grounds 3-4 days week.
- **Bothersome Problems:** Leg weakness, fatigue, low back pain
- **Top Priority:** Address fatigue, leg weakness & back pain to ride bicycle 2-3 days per week
- **Care preferences:** Too many meds and diabetes tasks causing fatigue and poor adherence. Likes PT and willing to do tests or procedures to address leg pain.

patient priorities care
Age-Friendly Health Systems

myhealth priorities

Identifying My Health Priorities

English

Welcome To My Health Priorities!

Through this process, we will help you identify what matters most to you: Your Health Priorities.

We will ask about your values, health goals and bothersome health problems to reach your top priority.

When you're finished, you will have a printable Health Priorities Summary you can share with your family and health care team.

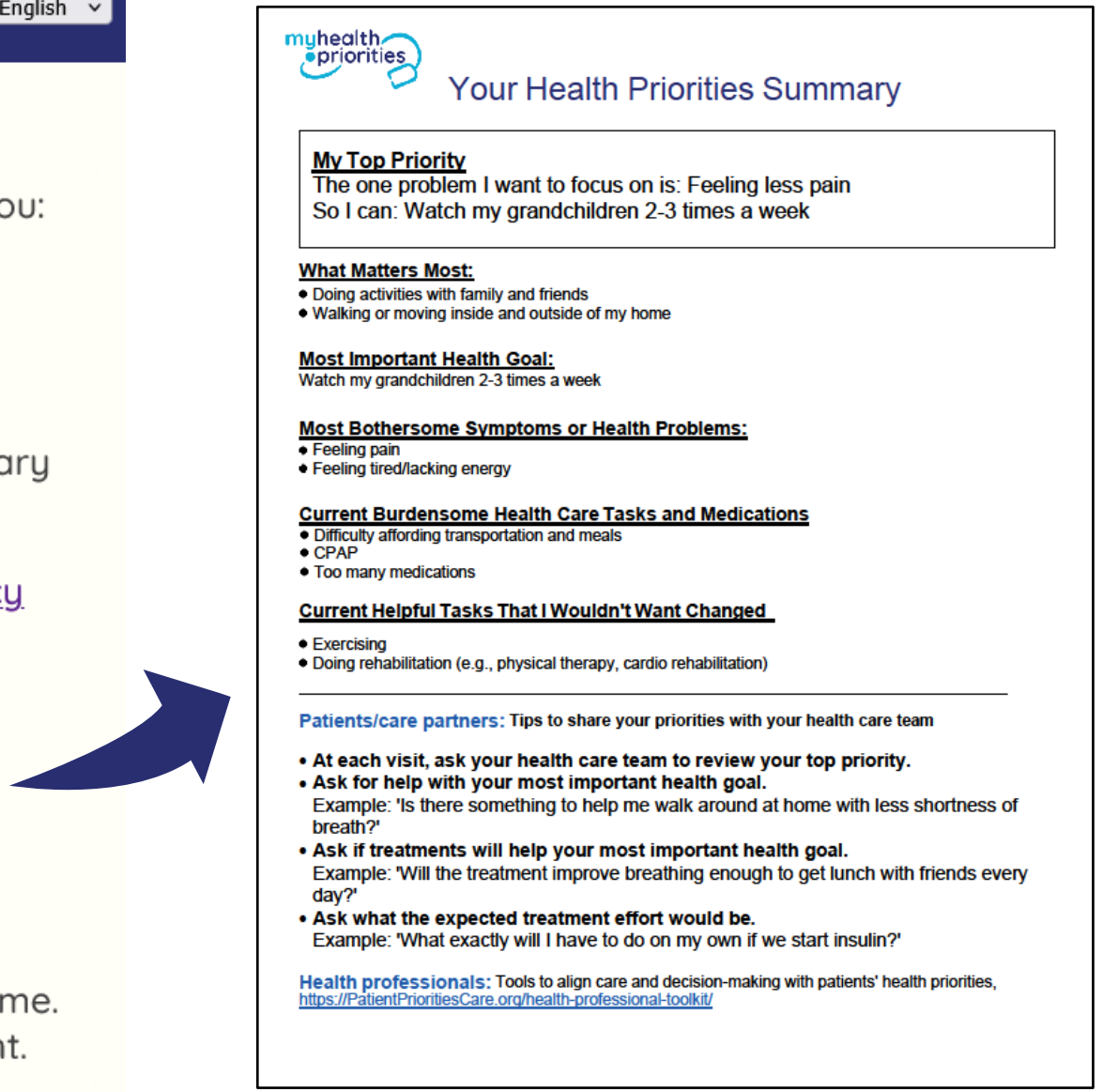
Protecting your privacy is important to us. Read more about our privacy policy.

myhealth priorities

Completing this questionnaire will take about **25-40 minutes** of your time. You will be able to save your work and return if you make an account.

Back | Next

(MyHealthPriorities.org)



myhealth priorities

Your Health Priorities Summary

My Top Priority
The one problem I want to focus on is: Feeling less pain
So I can: Watch my grandchildren 2-3 times a week

What Matters Most:
- Doing activities with family and friends
- Walking or moving inside and outside of my home

Most Important Health Goal:
Watch my grandchildren 2-3 times a week

Most Bothersome Symptoms or Health Problems:
- Feeling pain
- Feeling tired/lacking energy

Current Burdensome Health Care Tasks and Medications
- Difficulty affording transportation and meals
- CPAP
- Too many medications

Current Helpful Tasks That I Wouldn't Want Changed
- Exercising
- Doing rehabilitation (e.g., physical therapy, cardio rehabilitation)

Patients/care partners: Tips to share your priorities with your health care team

- **At each visit, ask your health care team to review your top priority.**
- **Ask for help with your most important health goal.**
  Example: 'Is there something to help me walk around at home with less shortness of breath?'
- **Ask if treatments will help your most important health goal.**
  Example: 'Will the treatment improve breathing enough to get lunch with friends every day?'
- **Ask what the expected treatment effort would be.**
  Example: 'What exactly will I have to do on my own if we start insulin?'

Health professionals: Tools to align care and decision-making with patients' health priorities, https://PatientPrioritiesCare.org/health-professional-toolkit/

*Version 2.0 was generously funded by the Nancy and Clive Runnells Foundation and the Pierce Runnells Foundation

patient priorities care
Age-Friendly Health Systems

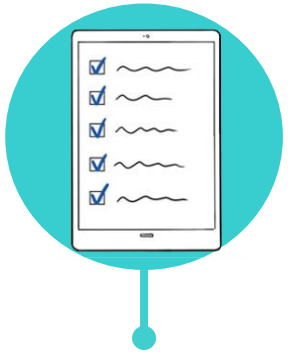
Align care with Mr. JW's health priorities

- **Top Priority:** Address Fatigue, leg weakness & back pain getting in the way of his goal to ride bicycle 1-2 days/week
- **Align care to achieve priorities:**
  1. Epidural injection for back pain, allowed sitting on his bicycle to reach his goal
  2. Care preference for less intensive diabetes regimen--Increased adherence to diet, lost 5 lbs, and improved HbA1c
  3. Priorities-aligned care grew relationships and trust that fostered buy-in and motivation

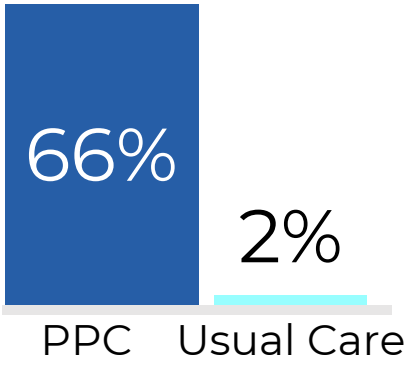
patient priorities care
Age-Friendly Health Systems

What we know so far…

Patient priorities aligned care is effective



Focus on patient's goals



↓ Unwanted care

- ✓ Medications stopped (2-3x less)
- ✓ Tests ordered (~30% fewer)
- ✓ Self-management added (30% fewer)

↓ Treatment burden

(TBQ; p=0.04)

No adverse events

↓ED visits
More days to home

Tinetti, Naik et al. JAMA Int Med 2019
Freytag, Naik et al. JAGS 2020

Formative Evaluation of Implementation

- Two distinct home-based primary care programs (Texas and North Carolina)
- Two primary care networks in VA system (Texas & Connecticut)

PARIHS Framework*	Low Implementation Success	High Implementation Success
Evidence	• High evidence to support effectiveness • High degree of patient engagement • Moderate degree clinical consensus at implementation site	• High evidence to support effectiveness • High degree of patient engagement • High degree of clinical consensus at implementation site
Context	• Established workflows and division of responsibilities • High resistance to deviation from status quo • "Top-down" implementation	• Newly established program or newer leadership • Innovation highly valued • Patient-centered culture • "Bottom-up" implementation but with leadership support
Facilitation	• Internal facilitation leadership unstable • External facilitators played a larger role in implementation effort (biweekly meetings) • Directive and collaborative facilitation	• Internal facilitators are open, supportive, approachable • Monthly/Quarterly meetings with external facilitators • Collaborative facilitation with timely engagement by internal facilitators when needed

*Promoting Action on Research in Health Services (PARIHS)framework

Sustainability & Dissemination Challenges

1) **“Innovation fatigue”** from competing demands and initiatives

2) **Complex web of entities** with differing incentives and missions that must be reached

3) **Tension between strict adherence to PPC steps & “casual” uptake**

4) **Focus of most quality and payment metrics on disease**, not patient priorities-centric care

Strategies to promote sustainability and broad dissemination

1) **Embed Patient Priorities Care into existing models and innovations** (e.g., Age-Friendly Health Systems, GUIDE model rather than being "one more thing"
2) **Target groups with specific messaging (e.g.,** health system leadership, health professionals, older adults and their care partners, and national organizations
3) **Instill Patient Priorities Care within the training** of health professionals
4) **Participate in development and testing** of Person-Centered Outcome metrics that support patient priorities-aligned care
5) **Make training and point-of-care resources widely available** to foster passive diffusion
6) **Access advice and counsel from experts** on issues such as licensing, consultancies, and when and how to monetize resources

Question Mark Abstract Geometric - Free vector graphic on Pixabay

Panel Discussion

What is something you can do now to advance Person-Centered Care Planning?

Question for the Audience

What new opportunities can drive Person-Centered Care Planning implementation forward?



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Main Findings from March Summit and Reports

David Dorr, MD, MS, FACMI, FAMIA, FIAHSI

PCCP4P Co-Director

Chief Research Information Officer

Oregon Health & Science University

OHSU

Main Findings from the March Summit and Reports: Barriers & Potential Solutions

Capacity needs for PCCP scale and spread

- Technology infrastructure and training, resources, guidelines, billing support, and leadership support to integrate PCCP into routine practice
- Reorganize care delivery, focusing on the need to use team-based approaches to PCCP;
- Incorporate care navigation into patient care and experience; and
- Incorporate meaningful involvement with community-based and related organizations.

Roles for Payors and Policy Makers

- Align payment and incentives with PCCP metrics to support providing person-centered care
- Multi-payer models should incorporate PCCP process metrics that capture the full scope of patient-centered outcomes

Main Findings from March Summit and Reports: Strategy

- **Cross-sector actions to improve PCCP implementation**
  - Build awareness of PCCP as a way of providing and receiving care
  - Spread success stories, successful models of PCCP or its components to encourage adoption and adaptation in new settings
  - Develop interdisciplinary training and accreditation that incorporates person-centered care
  - Develop and spread health information technology tools to support PCCP
  - Increase implementation research and evaluation to advance PCCP into large-scale implementation and scale-up across the healthcare landscape



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Future Directions & Summary

David Dorr, MD, MS, FACMI, FAMIA, FIAHSI

PCCP4P Co-Director

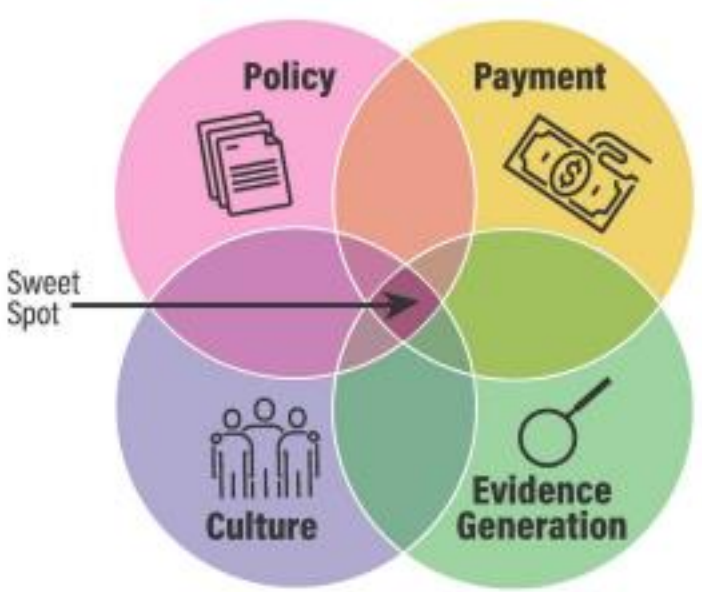
Chief Research Information Officer

Oregon Health & Science University

OHSU

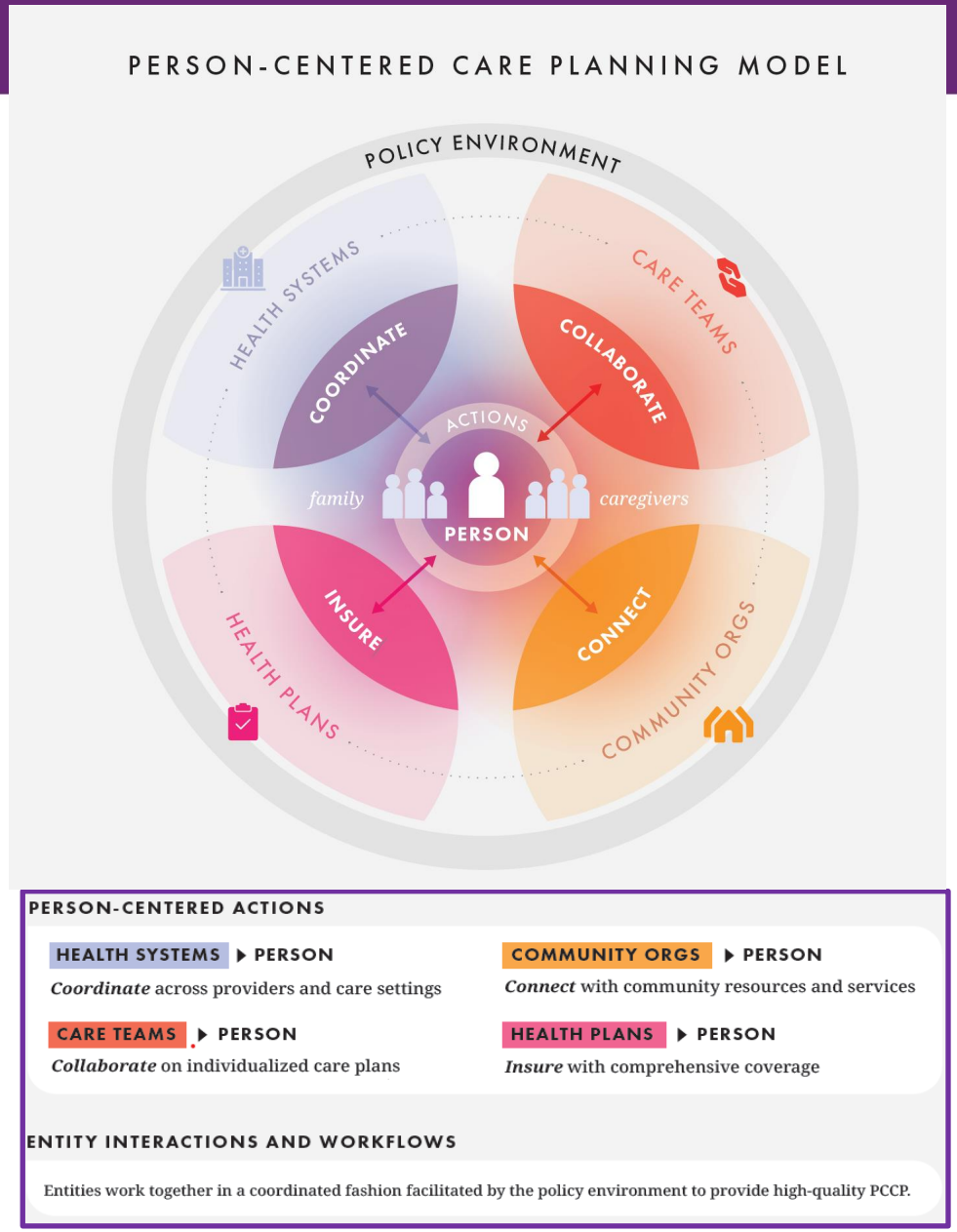
PCCP4P Task Order Goal

To facilitate bi-directional learning of promising models of person-centered care planning efforts for people with MCC and co-develop solutions to scale and spread PCCP.



-Agency for Healthcare Research and Quality

Expanded model of PCCP



- **Public Awareness & Adoption**
- **Impact of Leadership in Adoption**
- **Scaling Beyond Pilots** : 40+ models!
- **Reducing Healthcare Fragmentation**
- **Reducing Burden**
- **Patient-centered AI**
- **Integrating Patient-Generated Data**
- **Developing Standardized PCCP Metrics**
- **Process Metrics & Patient Independence**
- **Clinical Change & Storytelling**
- **Role of Patient & Family Advisors**

What is Needed for Adoption and Scale

Research	*implementation science to enhance evidence base*
Quality Measures	*emphasize relationships and continuity of care*
Payment and Resources	*scaffolding*
Workforce	*training in multidisciplinary team-based care and care coordination*
Local Context	*population service, available resources, workforce*



Questions?


THANK YOU!

Abbreviations:

PCCP4P: Person-Centered Care Planning for Persons

MCC: Multiple Chronic Conditions

CER: Comparative clinical Effectiveness Research