Agency for Healthcare Research and Quality
Person-Centered Care Planning for Persons with Multiple Chronic Conditions
Summary of Learning Collaborative Session #2 – August 13, 2024

<u>**AHRQ Partners in Attendance:**</u> Arlene Bierman, MD, MS; Kisha Coa, PhD; Vonetta Dotson, PhD; Elizabeth Hamilton, MPH, CPQH; Brenda Harding, MA

<u>**Project Team Members in Attendance:**</u> Alice Bonner, PhD, RN, FAAN; Emilia De Marchis, MD, MAS; David Dorr, MD, MS; Christie Jackson, MPH; LeAnn Michaels, BS; Lyndsey Miller, PhD; Kate Peak, MPH; Annette Totten, PhD

<u>**Learning Collaborative Members in Attendance:**</u>
Neeraj Arora, PhD, PCORI
Kasey Boehmer, PhD, MPH, Mayo Clinic
Soo Borson, MD, Keck USC School of Medicine
Malaz Boustani, MD, MPH, Indiana University
Barrett Bowling, MD, MSPH, Duke University
Edith Burns, MD, Zucker School of Medicine at Northwell
Maria Carney, MD, MACP, Northwell Health
Tom Cornwell, MD, Village Medical at Home/VillageMD
Lenise Cummings-Vaughn, MD, Center for Medicare and Medicaid Services
Melissa deCardi Hladek, PhD, CRNP, FNP, John Hopkins University
Samuel Edwards, MD, VA Portland Health Care System
Jonathan Flacker, MD, Chen Med
Christian Furman, MD, MSPH, University of Louisville
Robyn Golden, LCSW, Rush University
Jane Jih, MD, MPH, MAS, University of California San Francisco
Vijay Kannan, MD, MPH, Indian Health Service Headquarters
Kim Kuebler, DNP, APRN, Multiple Chronic Conditions Resource Center
Tracy Ellen Lippard, MD, Kaiser Permanente
Joan Monin, PhD, Yale School of Public Health
Stephanie Nothelle, MD, John Hopkins University
Ugochi Ohuabunwa, MD, Professor of Medicine, Emory University
Jane Pederson, MD, MS, Stratis Health
David Reuben, MD, University of California Los Angeles
Rafael Samper-Ternent, MD, University of Texas Health- Houston; PCCP4P TEP Member
Rob Schreiber, MD, myPlace Health
Saul Weiner, MD, University of Illinois at Chicago
Kelly Rice Williams, PhD, MPH, UPMC Center for High-Value Health Care
Jiayun Xu, PhD, RN, Purdue University School of Nursing

<u>**Learning Collaborative Members Not in Attendance:**</u>
Larissa Aviles-Santa, MD, MPH, National Institute on Minority Health and Health Disparities; **Sandy Atkins,** Partners in Care Foundation; **Cynthia Boyd, MD, MPH,** Johns Hopkins Division of Geriatric Medicine and Gerontology; **Barbara Bokhour, PhD,** Center for Healthcare Organization and Implementation Research; **Anna Chodos, MD,** University of California San Francisco; **Jose Figueroa, MD,**

Assistant Professor, Health Policy and Management, Harvard University; **Christina Frazel, MD,** Hennepin Healthcare; **Eric Gascho,** National Health Council; **Alex Krist, MD, MPH,** Virginia Commonwealth University; **Elizabeth Kvale, MD, MSPH,** VA What Matters Program; **Jessica Ma, MD,** Duke University, Durham Veterans Association; **Julie Parker, LCMHC, CCM,** Vermont's Blueprint for Health; **Katherine Ritchey, DO, MPH,** VA Puget Sound Health Care System; **Barbara Sullivan,** Patient Advocate; **Sarah Szanton, PhD, RN,** John Hopkins School of Nursing; **Nancy Wood, MDiv, ACPE Certified Educator,** University of Vermont Medical Center

Meeting Summary

A. Overview

Dr. Emilia De Marchis and Dr. Lyndsey Miller led the second Learning Collaborative (LC) session which included the Baseline Environmental Scan results (Task #2), presentations on exemplar models or approaches to person-centered care planning (PCCP), and two small group discussions. The first breakout session focused on implementation of the seven core PCCP components (see Section D) where LC members identified which components are most implementable in the short- and long-term, what resources/supports are needed for implementation, what existing resources can be leveraged, and what challenges and facilitators they faced within these elements. The second breakout session was an opportunity for LC members who work in similar settings (e.g., research, direct care, advocacy) to share their current experiences with specific models and approaches. Each group shared key learnings including what they have found innovative and promising, pros and cons of different models, and adaptations needed to scale to other settings.

B. Opening Remarks

Dr. Arlene Bierman opened the LC meeting with several AHRQ updates. AHRQ just released its Strategic Plan for Health System Transformation to Optimize Health, Functional Status, and Well-being among Older Adults https://www.ahrq.gov/priority-populations/publications/aging-well.html. The 5 goals of the strategic plan relate to advancing PCCP by funding research, disseminating and implementing evidence, supporting training, expanding and creating synergies across AHRQ's portfolio, and developing strong federal, health system, public health, and private sector partnerships to increase impact. AHRQ contributed to a recent report to Congress produced by the Interagency Coordinating Committee on Healthy Aging and Age-Friendly Communities, Aging in the United States, A Strategic Framework for a National Plan on Aging https://acl.gov/sites/default/files/ICC-Aging/StrategicFramework-NationalPlanOnAging-2024.pdf, that set the groundwork for a national multisector plan on aging. Dr. Bierman encouraged LC members to respond to a special emphasis notice in health services research to address questions related to the development, implementation, evaluation, and scale of person-centered models of care to optimize physical and mental health, functional status, and the well-being among older adults. There will be opportunity to advance work to improve care for people at risk for or living with multiple chronic conditions in forthcoming funding announcements, AHRQ's Healthcare Extension Service to Accelerate Implementation of Patient-Centered Outcome Research Evidence into Practice, that will fund state-based healthcare cooperatives, a national coordinating center, and a national evaluation center.

C. Preliminary Results from the Baseline Environmental Scan

Annette Totten, PhD, Co-Director, Pacific Northwest Evidence-based Practice Center, OHSU

Dr. Annette Totten provided an overview of the baseline environmental scan methods and results. The baseline environmental scan aims to compile information about models and approaches that utilize PCCP principles in ambulatory care. In addition, under this task order, the team will conduct two rapid scans on topics recommended by the technical expert panel, partner roundtable, and the learning collaborative. An environmental scan is faster and more targeted than a systematic review that uses abbreviated methods.

The objective of the baseline environmental scan is to describe the current state of the field, summarize implementation experiences, shape future approaches, and identify information needs and priorities. The scan orients around three guiding questions: What are models and approaches implemented in the US for adults with multiple chronic conditions (MCC)? What evidence is available related to those models and approaches? What barriers and facilitators to implementation can be identified related to the models and approaches?

Selection criteria were organized using the PICOS framework (Populations, Interventions, Comparators, Outcomes, Study Design, and Settings). The team conducted a MEDLINE search and then completed data abstraction. The preliminary results included 996 abstracts, 187 full texts, and 12 referred sources and the team abstracted data from 71 articles and documents. The working list of models and approaches is at 35 and growing.

Data about models and approaches are organized into descriptions of what is different in each model or approach (e.g., new people or roles, payment, technology, tools, care, or clinical services), and identifying the essential elements of the model. Data was also organized by subgroups, such as settings, populations, and services or care components. Results describe common barriers to PCCP implementation that include the need for more resources, challenges instilling culture change, and misalignment with policies and practices. Facilitators to address these barriers include flexible and effective team composition, addressing culture change, and aligning with policies and practices.

The preliminary conclusions are that there is no shortage of ideas, models and approaches. No single model seems to have been widely and commonly applied. The environmental scan suggests the need for consideration of content of approaches and models, and needs for dissemination, uptake, spread, scale and sustainability.

The preliminary recommendations are to create low-barrier, low-risk ways to share experiences of what does and does not work; identify outcomes important to key interested constituencies, including people living with MCC; consider how models and approaches might rely less on staff; and be explicit about need for incremental vs. fundamental change.

Learning Community Discussion:

LC members surface some key challenges to studying, implementing and disseminating new models or approaches. Key challenges include the time to dissemination and breadth of innovation of PCCP models, and lack of incentives described in models. Innovators may start a project, but typically have less time to disseminate. Evaluators publish research on models, but this lengthens the time to dissemination. Another member queried whether the models and approaches in the environmental scan made fundamental changes to clinical care or if they utilized workarounds. This could be key for implementation. Lastly, current payment models present sizable barriers to collaboration and integrated care. Everybody sees the need for an integrated model of care, but when we get to implementation getting people to collaborate is hard because the incentives are not there. Health systems focus on expenses rather than cost savings in preventive measures that address social determinants of health. What are ways that healthcare systems share payment with CBOs? Advocating to health system administrators and financial officers is challenging. Engaging them in program design and implementation, including success metrics, is crucial for effective change.

LC members shared additional models and programs that would be beneficial to explore in the environmental scan, including Dr. Sarah Szanton's "Neighborhood Nursing", the VA's Contextualizing Care Program, the Village MD model, GUIDE Model, Herself Health in Minnesota, and the Six Domains of Health and Managing Your Loved One's Health.

D. Breakout Group #1: PCCP Components

In this first breakout group, LC members discussed strategies and resources necessary for successful implementation of PCCP. First, the seven core components of PCCP were reviewed:

1. **Holistic assessment:** physical, mental, and behavioral health conditions; functional status; personal preferences, values, priorities, and goals; socioeconomic, environmental, occupational, and cultural factors; and life roles and responsibilities
2. **Identifying priorities:** problems, needs and goals
3. **Choosing interventions** for prioritized problem areas, needs, and goals, including medical, behavioral, and social interventions and supports and minimize harmful interactions between treatments
4. **Delineating roles and responsibilities** of each care team member, including the person/family/caregivers
5. **Long-term monitoring** + follow-up across health systems/providers
6. **Information sharing, communication, and care coordination** across the entire care team, including the person/family/caregiver
7. **Empowering** persons, families, and caregivers to engage in self-management.

Then, each breakout group identified which components of PCCP are most implementable in the short- and long-term, what resources/supports are needed for implementation, what existing resources can be leveraged, and strategies to increase uptake and promote culture change. Participants were also asked to share what challenges and/or facilitators they have faced within these elements.

Key takeaways from the first breakout session include:

- **Metrics Development:** Focus on creating metrics to measure PCCP, such as emergency visits per 1,000 patients, days at home, and patient experience. These metrics should be easy to capture and standardized for usability.
- **Standards:** Develop standards to facilitate information sharing and interoperability across electronic health records (EHRs). This includes creating tools to document patient priorities and care planning.
- **Culture Change:** Promote a culture shift within healthcare to support PCCP. This involves training care teams, providing financial incentives, and empowering patients and families to expect and engage in PCC.

- **Shared Decision Making:** Encourage shared decision-making and self-management by training providers and patients and making it a standard expectation within health systems. This includes using quality reporting and metrics to incentivize these practices.
- **Holistic and Interdisciplinary Care**: Foster trust and holistic care through cultural humility and trauma-informed approaches. This includes identifying and documenting informal caregivers in EHRs and ensuring interdisciplinary approaches that connect patients to necessary resources.

Full results from the first breakout session can be reviewed in Appendix B.

E. Presentations

Presentation 1: GUIDE Model

David Reuben, MD: Archstone Professor of Medicine; Director of the Alzheimer and Dementia Care Program in the David Geffen School of Medicine at University of California, Los Angeles

The UCLA Alzheimer's and Dementia Care (ADC) Program started in 2011. The ADC Program partners with families, physicians, and community organizations to maximize function, independence, and dignity of persons living with dementia as well as minimize caregiver strain and burnout. As of July 25, 2024, 4,271 patients have been enrolled, 1,025 are active, 13 are scheduled, and 276 are on the wait list. The program follows a co-management model with a Nurse Practitioner Dementia Care Specialist (DCS) who works with the Primary Care Provider (PCP) and provides comprehensive care based in the community's health system. Some of the Community-Based Organizations (CBOs) that the program partners with include those that provide services for patients (e.g., adult day care services), services for families/caregivers (e.g., counseling and peer-to-peer support) and selected, short-term services, authorized by DCS (e.g., respite care).

In 2023, CMS announced a new voluntary nationwide model – the Guiding an Improved Dementia Experience (GUIDE) Model. The GUIDE Model aims to: improve the quality of life for people living with dementia, reduce burden and strain on unpaid caregivers of people living with dementia, and prevent or delay long-term nursing home care. The GUIDE Model is designed to define a standardized approach to dementia care delivery, provide an alternative payment methodology, address unpaid caregiver needs, pay for respite services, and screen for Health-Related Social Needs. It is available for patients who have Medicare Part A or B, and payments are based on involvement of a caregiver and level of acuity.

The GUIDE delivery approach has 9 requirements for services. Care must be delivered by an interdisciplinary team that has dementia expertise. Other requirements include training for care navigators, sharing a Person-Centered Care Plan with the patient, care coordination, and caregiver services. UCLA was funded to participate in this model in April 2024 and will participate for 8 years as a demonstration site before CMS decides whether to make GUIDE a permanent benefit based upon evidence from the evaluation. Of the approximate 6.9 million people with Alzheimer's disease and other related dementias, it is expected that GUIDE will cover about 200,000 people.

There was a question about opportunities to leverage the GUIDE learning model for insurers or health systems. GUIDE is a new CMMI model, not a program, and is not focused on insurers or health systems. However, the John A. Hartford Foundation is looking at that specific question and is funding efforts in this area.

Presentation 2: Patient Priorities Care

Aanand Naik, MD: Nancy P. & Vincent F. Guinee, M.D. Distinguished Chair; Director of the UTHealth Consortium on Aging; Professor of Medicine at the Joan and Stanford Alexander Division of Geriatrics and Palliative Medicine; Chair of the Department of Management, Policy, and Community Health at the UT Health Houston School of Public Health

Patient Priorities Care (PPC) addresses the issues facing older adults with complex care needs. PPC leverages the What Matters Most Framework (the 4 M's)—What Matters, Medication, Mobility, and Mentation—and aligns appropriate care to achieve patient goals. PPC starts with a dedicated visit during which the patient identifies their health priorities in a structured manner (e.g., current care patient finds helpful or burdensome). Once priorities are identified, the priorities are recorded in the EHR to share with all providers and members of the care team. From there, the goal is to align care with health priorities (e.g., consider interventions to start, stop, or continue based on these factors). Both steps can be updated as needed.

These conversations can be uploaded into a PPC Health Priorities Template, transmitted via EHR, which is easy to find and can be tracked across care providers. When providers align care with patient health priorities, the patient feels listened to, engaged, and motivated, which increases adherence. When reviewing identified priorities, providers should look at the whole person and consider conditions and life circumstances impeding their health goals, use health priorities as a focus of decision making and communication, and document changes in care related to patients' priorities.

Evidence from PPC shows that aligned care is effective. Compared with usual care, PPC is associated with a significant reduction in treatment burden and unwanted care (e.g., fewer unwanted tests), more days at home outside of medical care (40% decreased odds of ED visit), and increased satisfaction as care is more aligned with What Matters.

Following Dr. Naik's presentation, there was a question from LC members about which EHR vendors PPC has been integrated in. These include the VA and Epic, with other integrations in progress with PACE. Another question was asked regarding what additional evidence is needed for the PPC model. More evidence may be needed in the following areas: 1) How to most efficiently conduct patient priorities identification, 2) How/where/when to transmit the priorities to the clinicians that make treatment decisions, 3) how to incentivize clinicians to act on priorities when they are received (what is the best way to design a CMS incentive), and 4) the most efficient/effective ways to show that care alignment results in attainment of priority goals, and how reimbursement can be aligned with that endpoint.

Presentation 3: Care Management Plus

David Dorr, MD, MS, FACMI, FAMIA: Chief Research Information Officer, Professor and Vice Chair of the Department of Medical Informatics & Clinical Epidemiology, and Professor of Medicine at Oregon Health & Science University

Care Management Plus (CMP) was developed by people, one of them being Laurie Burns from InterMountain Healthcare, who were concerned about the care people were receiving at InterMountain when they had complex health issues. Dr. Burns started a program to change the model of care delivery with John A. Hartford funding and Dr. Dorr joined the program to disseminate the initial model. The mission of CMP is to improve systems and outcomes for vulnerable populations through research, technology, and collaboration.

Training is the foundation of CMP, with 1-2 days in person session followed by 8 weeks of online follow-up with skill practice. Training is focused on topics related to PCCP such as motivational interviewing, an important skill to help people both identify their goals through discussing what matters most to them, but also what actions they want to take at home. About 90% of trainees were nurses, but also social workers, CHWs, and other types of clinicians. Tools that CMP trainees learn include those that identify risk, especially health-related social risks. Another tool includes a care manager encounter list, where workflows can be established and tracked for team-based care when issues are complex. Dr. Dorr's team has also built summary sheets combined with standard measures that generate summarized clinical information and facilitate structured conversations around patient goals.

CMP has had generally positive results including longer lifespan for patients, patient reports of being healthier, and better control of chronic conditions such as diabetes; improved care manager and provider experience; 20-40% reduction in hospitalizations and costs; and improved patient and family experience. CMP also follows many of the PCCP components, specifically choosing interventions and long-term monitoring. Several implementation challenges have been encountered, such as figuring out how CMP "fits" into other QI effort and initiatives, and variable uptake in clinics.

Following Dr. Dorr's presentation, an LC member asked if there is a value proposition, return on Investment to implement the CMP approach, and whether this is predicated on payer mix for example, risk-based vs fee for service. There are three threads of value proposition in this model: 1) Direct payment (charging for chronic care management, 2) Improved health for the most vulnerable patients; costs can be lowered through these programs if the health system can capture (e.g., capitation, specific programs) and integration, and 3) Efficiency; while subtle, CMP showed improved team efficiency and RVU gen etc. in their early work. This is challenging given the burnout and stress, but may get better with new tools (e.g., AI, eConsults, etc.)

F. Breakout Group #2: Case Study Elements

Participants were asked to discuss their experiences with specific models/approaches to PCCP, and to highlight innovative/promising examples and pros/cons of the different approaches. Participants were also asked to discuss how those models/approaches should be adapted by setting/population/other factors.

Key takeaways from the second breakout session included:

1. **Implementation:** There are quite a few different models and approaches to PCCP with evidence to support their effectiveness, and some even have substantial funding. The next step is to think about how to implement these innovative approaches broadly and determine what outcomes will define successful implementation. We should also consider implementation from the caregiver perspective, especially around people with dementia and how caregivers assist with identifying patient priorities in these instances.
2. **Culture shift (funding):** There is a need for culture shift to support this work. Many PCCP models and approaches will not be successful under the current fee-for-service system.
3. **Culture shift (provider incentive):** Many providers are eager to implement PCCP and others are not due to the challenges they may encounter when attempting to implement a model or approach. It is important to learn what factors are motivational and what factors create challenges for care teams to deliver PCCP, and how to sustain that momentum. There is also a

need for culture shift in medical education and how clinicians are trained, and to provide ongoing PCCP training for clinicians.

4. **Adaptation:** Many key elements are aligned across models and approaches, but certain aspects of each approach must be tailored to specific populations, settings, and geographic areas. For example, there may be policy limitations in one state versus another. Telehealth and home health options also work better in some communities than others. Culturally appropriate adaptations take time and entail multiple components to ensure the adaptation is meaningful.
5. **Team-based care:** There is a need for team-based care rather than relying on the PCP to lead the way. Shifting the reliance onto partnerships between all members of the care team, including family and informal caregivers, is important to extend the reach of what primary care can do.

The full results from the second breakout session can be reviewed in Appendix C.

LC members suggested a culture shift in provider incentive to implement PCCP could start by involving clinicians who are eager and curious, and gradually include those who are not yet ready. It's important to understand what makes clinicians feel valued and heard, as everyone wants to contribute and do a good job. It is also crucial to align fee-for-service and value-based care billing with model components, moving away from traditional cost-benefit analysis.

G. Shared Resources and Links

AHRQ Resources

AHRQ Strategic Plan for Health System Transformation To Optimize Health, Functional Status, and Well-Being Among Older Adults https://www.ahrq.gov/priority-populations/publications/aging-well.html

Patient Priorities Care Resources

- Tools for patients/caregivers (electronic manual, tips), clinicians (electronic manuals, materials, publications, and key definitions) https://patientprioritiescare.org/
- Decisional guidance (tips & scripts) tool http://decisionguide.patientprioritiescare.org/
- Self-directed health priorities identification https://myhealthpriorities.org/

Online training modules, MOC, and CEUs credits available https://www.acponline.org/clinical-information/clinical-resources-products/decision-making-for-patients-with-multiple-chronic-conditions-patient-priorities-care

Additional Models and Programs Suggested by Learning Community

- Six Domains of Health https://www.ahrq.gov/talkingquality/measures/six-domains.html
- Managing Your Loved One's Health https://pubmed.ncbi.nlm.nih.gov/27384048/
- VAs Contextualizing Care Program https://pubmed.ncbi.nlm.nih.gov/34158194/
- Evaluation of a Patient-Collected Audio Audit and Feedback Quality Improvement Program on Clinician Attention to Patient Life Context and Health Care Costs in the Veterans Affairs Health Care System https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768922
- Neighborhood Nursing https://www.npr.org/sections/shots-health-news/2024/06/11/nx-s1-4997717/nurses-primary-care-community-baltimore-costa-rica
- Moving Forward Coalition https://movingforwardcoalition.org/taking-action/

APPENDIX B: Breakout #1 Results

Category	Whiteboard notes from LC Session 1	Implement-able in short(er) term?	Implement-able in long-term?	Strategies to increase uptake?	Effective ways of promoting culture change and buy in?	Resources that can be leveraged based on experience?	Resources needed based on experience?	What challenges have you experienced?	What facilitators have you experienced?
Metrics	Develop metrics on whether PCC occurred, if patients' needs are met, extent of collaboration(s). Focus metrics of success on goal attainment in addition to clinical markers (which may be facilitated via common EHRs). Standardized measures may not be appropriate for all assessments. Audit and feedback as one way to evaluate care team and patient interactions for patient priorities and circumstances incorporated into intervention planning.	Metrics must be easy (e.g., emergency visits per 1,000; days at home (particularly like this measure); % of patients on hospice); information that can be captured through claims and automated; scanned power of attorney; patient satisfaction measures that exist already; leveraging HEDIS tools, regulatory elements; documenting patient-centered goals that are tracked.	Metrics need to be standardized and usable, accessible way; need to have a good way to identify caregivers and other important information.	Information systems that are designed to support PCC; using HEDIS measures that organizations are accountable for; insurers tweaking payment to incentivize PCC; finding workarounds for existing EHRs/Gerry-mander.					
Standards/ guidelines	Develop standards/ guidelines to facilitate information sharing	"No, lack of statewide info exchange; multiple EHRs	Maybe/ hopefully. HL7 Interoperability.	Build tools to document patient priorities/care		Maybe HIEs? EHR templates utilizing HL7.	Likely payment push. Incentives	Switching EHRs can feel paralyzing	HIE (health information exchange)

	and interoperability (including EHRs that promote patient care).	w/limited data sharing. No incentives to change EHRs.		planning that work across EHRs.			for institutions to switch/ modify EHRs needed.	poor quality of existing data within EHRs What does note look like? Where do you find it in the EHR? How is it incorporated into care decisions? Go beyond billing requirement. Too much ends up in unstructured notes	may be helpful care planning/ priority tools that work across EHRs ways to search EHR data and import into notes.
Culture change within health care	Shift culture/achieve buy in for PCC and involvement of full care team, which may necessitate a change in how care team members are trained. Empower clinicians/care teams to deliver PCC.	goals of care conversations training; motivation interviewing training; not framing discussion around saving money but focus on aligning care with your priorities.	Incentives - financial; pay for health (not sickness).	Training around behavioral change discussions; financial incentives - VBC; defining bad end of life care as a never event; lead with quality - what are our goals? Remove concept of saving money because sometimes it's not cheaper; lower medical misery; logistical suffering.					
Shared decision	Enable/engage in true shared decision	Yes.		Communication training for	Shared decision	Enable/engage in true			

making, self-management	making and promoting/enabling self-management, including understanding patient/family relationships/dynamics, identifying both medical and non-medical goals/priorities based on individual values and disease trajectories, and delegating responsibility to patients/families.			providers, patients, families.	making, self-management.	shared decision making and promoting/enabling self-management, including understanding patient/ family relationships/ dynamics, identifying both medical and non-medical goals/priorities based on individual values and disease trajectories, and delegating responsibility to patients/ families.			
Trust and holistic care	Foster and build trust through cultural humility and trauma-informed approaches to care. Holistic assessments should include attention to language and digital literacy access, in addition to other SDoH and strengths-based assessments, including	some can be accomplished short-term	Some longer-term	"What we can do now: use EHR systems to identify informal caregiver; what takes more time: shifting SDM approaches.	Demonstrate cultural humility - understand how different patients engage the question in a different way. Cultural adaptations go beyond translation.	Health system buy-in is critical for meaningful cultural adaptation. Involve CHWs			

	community and home supports.								
Inter-disciplinary care	Interdisciplinary approach that includes connection to resources as part of interventions and use of motivational interviewing to determine patient priorities and interests. Interdisciplinary approaches may require changing billing structures to promote resourcing of all team members, including social work and chaplain services.					Need attention to holistic care to include spirituality.			
Resource enhance-ment	Increase resources within the health system (including RVUs/funding for this work, personnel with expertise) and partnerships in the community to help facilitate addressing holistic needs of patients/families. Different settings will have different resources across health systems and communities.								

APPENDIX C: Breakout 2 Results

Model type/ description	Successes	Obstacles	Measuring/ Evaluating (what/how)	Adaptations related to rurality/ urbanicity	Adaptations related to patient population	Adaptations related to local resources/ other context	Add other column as needed	Add other column as needed
General notes/ commonality	Themes across models/ approaches.	Culture shift to support this work. Need for interdisciplinary/ co-management approaches. Need for support included within primary care approach. Primary care becomes system not trans-actional. Primary care physicians are just one part of the system.	Lack of funding (don't' pay for team-based care, who gets paid [or not] is important but not enough done). Medicare funding is geared at physician payments. Back door approach to showing value in primary care; no front door. Traditional focus on clinicians; mismatch training and expectations/requirements of clinicians. focus on money saving. Clinicians trained to task completion, organization-based medicine. GOC is related to what the health system does to you, not actual goals of care. EHR notes/ ICD10 codes don't capture patient story. Need to change med edu.	For clinicians: audit/feedback. how to make sure data is high quality/ consistent.	Challenges around volume/service area in rural areas. Using EMS to do visits in rural communities. Re: rurality: Video visits OK but need home visit; contract with home care agencies (Univ. OK, partnering with statewide agencies). ECHO model: expertise doesn't have to be local.	Cultural diversity raises the question of how to find care givers that are of the same culture to be involved in the care of the older adult. Also, equity issues and PTSD for a lot of these populations must be addressed; still questions around adapting for patient cultures; what is staffing, language, settings, follow up?	How to get systems to invest/ continue to support across settings/ resources.	

GUIDE	This funding is key to serving/ expanding to backlog for families; reduced waiting list principles can be incorporated into other models/ approaches. KP is Medicare advantage; try to construct similar dementia care program	Medicare Advantage beneficiaries do not have access at this point Not many have outcomes; payment model attached, what are the remaining needs? Want to optimize $$; How to diversify patients Challenges persist for people who have done this a long time PCPs are spread thin, but still willing to take on more. How to minimize their burnout? PCPs spread thin what is the trade off in time to reduce burnout? 400 sites chosen and now being implemented.	Will need services longer, changing needs Need a lot of evidence to bring people up to speed, research needs to shift to adaptations for setting. Show that payment models work making the public and providers aware of the approach and getting enrollment. Patient experience.	Needed I think there are measures already in place.	Can be adapted to MCC patients and families, support family caregivers; Patients who do not have caregivers are not included in this model This should be able to scale rurally the issues of culture competence and equity is a factor not fully accounted for.	Needed.	How to transition this to other FFS environments How to align payment so it supports program rather than being a barrier? MCC is group of people with healthcare/expense needs, no way to make it totally inexpensive. What is the outcome to make this worth doing? Reduce wasteful care? Shift resources to PCP so you don't need a donor to make this happen. RVU driven payment models. AI has a role here for routine stuff (automated dx) to free up PCP workload.	How to share the information gained through these models? PCPs don't have time to disseminate the specifics. OHSU has some lists that have worked for ACP so people can see them. Change in admissions for PCPs that have patient centered mindset, or they lose it in training.

Patient Priorities Care	Exceptional focus on identifying and working together on priorities for patients; intuitive and clear like the way they ask questions (1) People living with dementia with MCCs with different levels of impairment have been able to do the health priorities identification process, and care partners witness this and helps them be better decision-making partners now and in the future.	Teaching: Internal Med residents don't get it, don't understand why time spent asking theoretical questions. Required a lot of background work, time intensive; don't see pay off during their geriatrics rotation and don't get it anywhere else So hard to scale this; split between believers and nonbelievers. Improved focus on goals, reduction of burden, improved key outcomes (days at home) Implementation barriers many think they are already doing this. To go through all steps, run into inertia or hesitation. Need additional training support to practice in this way. Also, adjustments to workflow. (1) How do you wrestle with the intersection of social determinants of	requires different approach then what has been done traditionally 2 key measurement items: reduction in treatment burden + CollaboRATE scale; also collect days at home and qualitative indicators of satisfaction (patients and clinicians); could conduct cost analysis may be more appropriate to show how to align within a billing model (CCM, ACM models) CollaboRATE 3 item measure is an easy post visit measure, goal attainment scaling	Depends on the system	This should be able to scale rurally the issues of culture competence and equity is a factor not fully accounted for Dementia, multimorbidity, Hispanic participants have some indicators of how adaptations have made a difference. Culturally appropriate adaptations have been successful. Adaptations: does what we're asking make sense? Translate, then conduct focus groups with target population to find out whether the questions are relevant and able to capture real concerns; made revisions; evaluated with bilingual clinical experts; then back translated and made sure aligned with original PPC approach; final clarifications. Adapting for involving care partners of persons living with	PPC is now being disseminated in PACE programs and there are trainings specifically around how to do in PACE is in place. In VA setting veterans would be welcoming to PPC; need time for training staff. Need some adaptations, and can be supported via consultations. In VA settings, need workforce support. In non-VA, also needs payment approach. Social needs may trump medical needs. https://pubmed.ncbi.nlm.nih.gov/37983054/		

		health with the medical aspects of health. (2) How to involve care partners when it is a person living with dementia with MCCs?			dementia (and other disease contexts); caregiving dynamics impacts ability to standardize also impacts reporting on patient's priorities			
Care Management Plus	Large scale dissemination; strong focus on technology and team redesign with adaptability to different settings Similar to Kaiser model	Specialist involvement sometimes at odds with PCCP (or impractical/ unaffordable)	Large scale CMMI initiatives do not show care management savings; fidelity lost through many implementations Knowing the patient					
Additional models suggested from chat								
PACE (Program for All inclusive Care for the Elderly)		Is now growing and business case has been shown.	Scaling.	There are older outcome studies, but no randomized control studies done though and not updated. There are benchmarks that can be used to compare but these are not RCTS.	PACE is now in rural areas and is attempting to grow. There are challenges here due to the cost although some programs are being successful doing this.			

Minimally Disruptive Medicine	Paradigm of providing care that fits patients' goals with least healthcare footprint in their lives.	Building of small interventions that help patients and healthcare teams think about treatment burden and patient capacity available.	funding especially at large scale: clinicians often see their own workload/capacity imbalanced making any shifting difficult.	We have multiple measures of treatment burden in multimorbidity now; no existing measures of patient capacity based upon theory of patient capacity. Quality of life and other PROMIS measures can also be used to measure success.		Payment matters: payment that focuses on per person patient centered care vs fee for service.		
Moving Forward Coalition		Demonstrated innovative approaches.						
Six Domains of Health and Managing Your Loved One's Health	RN training program: generalized geriatric model for dementia care, focus on no crisis care.							
CAPABLE (community aging in place advancing better living for elders) program	Decreases hospitalizations & nursing home admissions, decreases pain & depression, improves function & self-efficacy Function within ecological valid setting (home);	Simple intervention can have powerful impact State by state limitations in policy and what is allowed (e.g. CT requires an RN at first visit); need community workers/handymen trained how to get them paid for services and	Saves $20k per person over 2 years, costs $3500~ not funded; need to show savings Function within ecological valid setting (home) improved, pain and depressive sxs improved, decreased nursing home admissions. Cost savings $20k/2 years per person. Intervention cost		Dementia and caregivers, older adults awaiting kidney transplant, older adults experiencing social isolation Homebased, dementia and caregivers (CAPABLE-Family), older adults awaiting kidney transplant (CAPABLE	State legislation may require different components of the program.		

	patient directed, self-efficacy based 3-person intervention team: nurse, occupational therapist and handy worker.	benefit community.	~$3500 over 4 months. Currently in 23 States, 48 sites, seeking more long-term national CMS and State funding, CAPABLE has a scaling center here: https://capablenationalcenter.org/		Transplant), older adults experiencing social isolation			
Primary Care Plus (KP-Colorado model)	Quadruple aims successes: better quality outcomes screening for depression/ anxiety, gathering advanced directives; clinically significant pharmacy changes deprescribing or getting people on medicines that are needed for their conditions, dosing changes; patient satisfaction people loved the program; provider satisfaction PCP-based model (provided	graduating people back to usual care, so you can enroll new people; getting people to engage who are identified; challenging to sell a care management program (terminology matters) ; logistics of creating space for inter-disciplinary team conversations can do some through EHR, but also helpful to have time to talk for 1015 minutes about a patient hard to find the time for this (would also ideally include patient and caregiver); cultural challenges not use to thinking	written about in a few publications include Harvard Business Review; social needs, depression/anxiety, caregiver support; getting at what matters most to you, patient centered goal setting	Kaiser Colorado is mainly urban/suburban, not a lot of rural; has diffused out some	persistently high costs patients; tiered model for follow-up (well 3-month telephonic outreach; if changes higher touch tier 1/month + direct phone # to their care coordinator (RN); focus on graduation. The goal is to not have people on high intensity programs long term	Key learning: a proactive approach not reactive; some other models of care- people with underlying mental health issues and frequently going to ER; built a clinic next door to the ER that had appropriate staff to treat mental health (meeting people where they are and save costs by not going to the ER); opportunities to partner with palliative care to share info about diagnosis/prognosis in a sensitive way	identify targeted population based on outcomes you're trying to achieve; one goal = maintain costs	

	interdisciplinary team support).	about things this way patient centered goal setting, motivational interviewing, behavior change, modeling how to use them						
Bridge	Social workers and other team-based roles can help set priorities	Team based care is challenging to fund						
Renal Silver	Focuses on population of veterans with kidney disease. Older adults with kidney disease must decide whether to pursue dialysis. This model helps with making of decision.	Specialty based care is very disease-oriented (nephrology) that relies on labs for decision making.	# that received care; changes to care as result of focusing on priorities; geriatric syndromes; referral to geriatric services; qualitative	Rural- delivery by telehealth, which can be preferred. Specialists may not be sensitive to running telehealth visits		Relies on partnership with geriatrics, and have limited reach without geriatrics, even via telehealth		
Patient-Centered Medical Home (PCMH)		Areas that have not expanded Medicaid led to limited implementation. Workforce retention (case managers, providers) and coordination; challenging to get records from ER visits.				Addressing HRSN is challenging in the safety net model in general. Having framework can work well for implementation.		

Better public health in general								
Neighbor-hood Nursing	https://www.npr.org/sections/shotshealthnews/2024/06/11/nxs14997717/nursesprimarycarecommunitybaltimorecostarica							