Agency for Healthcare Research and Quality
Person-Centered Care Planning for Persons with Multiple Chronic Conditions
Summary of Learning Collaborative Session #3 – September 30, 2024

AHRQ Partners in Attendance: Arlene Bierman, MD, MS; Kisha Coa, PhD; Karen Fortuna, PhD; Elizabeth Hamilton, MPH, CPQH; Brenda Harding, MA; Jose Plascencia, PhD

Project Team Members in Attendance: 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

Learning Collaborative Members in Attendance:
Neeraj Arora, PhD, PCORI
Sandy Atkins, Partners in Care Foundation
Larissa Aviles-Santa, MD, MPH, National Institute on Minority Health and Health Disparities
Soo Borson, MD, Keck USC School of Medicine
Barrett Bowling, MD, MSPH, Duke University
Samuel Edwards, MD, VA Portland Health Care System
Jonathan Flacker, MD, Chen Med
Eric Gascho, National Health Council
Robyn Golden, LCSW, Rush University
Melissa deCardi Hladek, PhD, CRNP, FNP, John Hopkins University
Rodger Kessler, PhD, DARTNet Institute
Kim Kuebler, DNP, APRN, Multiple Chronic Conditions Resource Center
Joan Monin, PhD, Yale School of Public Health
Stephanie Nothelle, MD, John Hopkins University
Jane Pederson, MD, MS, Stratis Health
David Reuben, MD, University of California Los Angeles
Katherine Ritchey, DO, MPH, VA Puget Sound Health Care System
Brittany Watson, MD, MPH, BSN, FAAFP, NC Medicaid
Kelly Rice Williams, PhD, MPH, UPMC Center for High-Value Health Care

Invited speakers: Paul Ciechanowski, MD, MPH; Danielle Hessler Jones, PhD; Bhumika Chudasama, MD; Susan Kwiatek, DNP

Learning Collaborative Members Not in Attendance:
Kasey Boehmer, PhD, MPH, Mayo Clinic; **Malaz Boustani, MD, MPH,** Indiana University; **Cynthia Boyd, MD, MPH,** Johns Hopkins Division of Geriatric Medicine and Gerontology; **Barbara Bokhour, PhD,** Center for Healthcare Organization and Implementation Research; **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
Anna Chodos, MD, University of California San Francisco; **Jose Figueroa, MD,** Assistant Professor, Health Policy and Management, Harvard University; **Christina Frazel, MD,** Hennepin Healthcare; **Christian Furman, MD, MSPH,** University of Louisville; **Jane Jih, MD, MPH, MAS,** University of California San Francisco; **Vijay Kannan, MD, MPH,** Indian Health Service Headquarters; **Alex Krist, MD, MPH,** Virginia Commonwealth University; **Elizabeth Kvale, MD, MSPH,** VA What Matters Program; **Jessica Ma, MD,** Duke University, Durham Veterans Association; **Tracy Ellen Lippard, MD,** Kaiser Permanente; **Ugochi Ohuabunwa, MD,** Professor of Medicine, Emory University; **Julie Parker, LCMHC, CCM,** Vermont's

Blueprint for Health; **Rob Schreiber, MD,** myPlace Health; **Barbara Sullivan,** Patient Advocate; **Sarah Szanton, PhD, RN,** John Hopkins School of Nursing; **Saul Weiner, MD,** University of Illinois at Chicago; **Jiayun Xu, PhD, RN,** Purdue University School of Nursing

Recording Info:

https://zoom.us/rec/play/yBhcqA8sdjGEALwHn0GDsQ6pv9FaI2AnF3aXRqT6JNIyVcKAHaIGYVFOaSD2NYhHLIpvkd3DbrRK_QDH.7Q7ZyvJdkXqMZwh5?canPlayFromShare=true&from=my_recording&continueMode=true&componentName=rec-play&originRequestUrl=https%3A%2F%2Fzoom.us%2Frec%2Fshare%2F500Ho7DxrkaDvmYsdZ5q5Yl6Iiij5zAWNrXcDdEbkYsbPc-1faoQ6nUlrfotATh7.ELGWakKATZ51OZYb

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Meeting Summary

Overview

Dr. Emilia De Marchis and Dr. Lyndsey Miller led the third Learning Collaborative (LC) session which included an update from Dr. Arlene Bierman, three case studies and a review of LC Meeting #2.

AHRQ Update

Dr. Arlene Bierman shared new AHRQ funding opportunities to establish state-based collaboratives to accelerate health care improvement, described here https://www.ahrq.gov/news/newsroom/press-releases/state-based-health-extension-cooperatives.html

AHRQ is developing the eCare Plan and MyCarePlanner applications to facilitate shared care planning to support people with multiple chronic conditions (MCC). The eCare Plan can aggregate data from multiple EHRs and include data on social needs, caregiver needs, and function. The eCare Plan FHIR Implementation Guide is being shared publicly, https://hl7.org/fhir/us/mcc/STU1/index, html to support other care coordination efforts.

Dr. Bierman identified similarities between the WHO ICOPE approach and Learning Collaborative discussions. The ICOPE handbook (https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1) could be a useful resource. Dr. Bierman and co-authors recently published a qualitative analysis of PCCP for people living with or at risk of developing multiple chronic conditions resulting from an earlier RFI. This study highlights current barriers and opportunities to transform care delivery and coordination. (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2824977)

LC Session #2 Recap

Dr. De Marchis summarized themes of implementation facilitators and PCCP models from the previous Learning Collaborative session (see slides 29-34).

LC members were prompted with the question, “What PCCP implementation facilitators have you noticed or thought more about since learning collaborative session #2?”

Defining overall goals of care is a problem, since care and subsequent goals are often specialty/specialist based. Dr. Borson called for a serious conversation about what we are trying to accomplish across all conditions and all patients. There are not yet cross-cutting goals of care in theory or practice. At Northwell, Goals of Care and What Matters Most conversations are taught to all levels of staff. Additionally, Johns Hopkins FNP and AGNP students learn about What Matters Most using the Patient Priorities Care framework. Dr. Reuben reflected that "Goals of care" can be perceived by community members as advanced care (e.g., resuscitation) or cost-saving measures that are focused on reducing utilization but framed as comfort measures. The patient, clinician and payor all have separate agendas. The PCP should support the patients' agenda. Drs. Reuben and Hladek shared the following papers related to this conversation.

Reuben DB, Tinetti ME. Goal-oriented patient care--an alternative health outcomes paradigm. N Engl J Med. 2012 Mar 1;366(9):777-9. doi: 10.1056/NEJMp1113631. PMID: 22375966.

Reuben DB, Jennings LA. Putting Goal-Oriented Patient Care Into Practice. J Am Geriatr Soc. 2019 Jul;67(7):1342-1344. doi: 10.1111/jgs.15885. Epub 2019 Mar 18. PMID: 30882888.

Tinetti ME, Hladek MD, Ejem D. One Size Fits All-An Underappreciated Health Inequity. JAMA Intern Med. 2024 Jan 1;184(1):7-8. doi: 10.1001/jamainternmed.2023.6035. PMID: 37983054.

One barrier beyond identifying patient goals of care, is clarifying clinician goals. AHRQ's eCarePlan can collect goals from clinicians, patients, and caregivers to start a conversation to align goals and get all invested parties on the same page.

Case Study I: Initiating and Scaling Collaborative Care for Persons With/At Risk for Multiple Chronic Conditions

Presenter: Paul Ciechanowski, MD, MPH, Clinical Associate Professor, Dept of Psychiatry, University of Washington and Chief Medical Officer, Janus Healthcare Partners

Dr. Ciechanowski gave an overview of Collaborative Care as defined by AHRQ, "A team with a shared mission, using improved clinical systems to deliver improved care to a patient population supported by operational and financial systems. Such care is continuously evaluated through improvement processes and effectiveness measurement."

Dr. Ciechanowski helped develop the Program to Encourage Active, Rewarding Lives (PEARLS) program for older adults with social isolation and high MCC burden through home-based care collaborative care and other tools. The program had a positive impact on participants' depression remission. More information about PEARLS and their corresponding training is available on their website, https://depts.washington.edu/hprc/programs-tools/pearls/.

Dr. Ciechanowski discussed the problem of clinical inertia, the lack of treatment intensification in a patient not at evidence-based goals for care, which has been linked to suboptimal MCC control. This clinical inertia can be seen at patient, clinician, and administrative levels. The Collaborative Care model can be effective against this growing problem. There are now billing codes for Collaborative Care, but there is a risk of poor fidelity to the model and poorer outcomes. In Michigan, a collaboration has formed between a physician organization, the state's Blue Cross Blue Shield, the University of Michigan

Medicine and Michigan Institute for Care Management and Transformation to ensure fidelity is maintained through incentives.

Discussion

LC members raised real world examples that threaten the integrity and fidelity of Collaborative Care, including lack of monitoring, staffing shortages, use of temporary providers, and centralized scheduling systems that put patients in with the next available provider who may not know them. To incentivize clinical fidelity, payors can audit programs to ensure they have all components of Collaborative Care for payment. From a Collaborative Care perspective, the primary care provider (PCP) is the quarterback of engagement; the PCP/patient relationship is key.

Another LC member asked how to address care for patients whose SDOH needs are much higher than their health outcome needs and often co-occur with mental illness. In Collaborative Care, an SDOH profile is collected so the clinical team can help determine how to address those needs. Additionally, Dr. Ciechanowski found that skill building through problem solving treatment and behavioral activation is a powerful way to help people with depression in the PEARLS program.

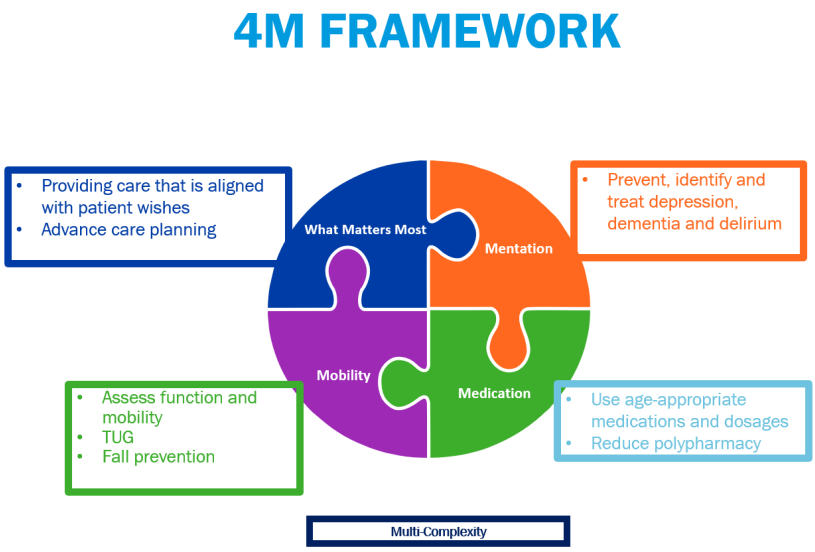
Dr. Ciechanowski now works with Janus Healthcare Partners to implement their Collaborative Care Model (CoCM) at clinical sites. In this work, their team builds relationships and trust with clinical staff by supporting their work, sometimes proactively conducting patient outreach, to develop the CoCM program at that site. (https://janushcp.com/)

Case Study II: Northwell Health

Presenters: Bhumika Chudasama, MD, Hospice and Palliative Care, Northwell Health and Susan Kwiatek, DNP, VP Aging and Supportive Care, Northwell Health

Dr. Chudasama gave a thorough review of the 4Ms, (Mobility, Mentation, Medication, and What Matters Most) using case examples to illustrate the benefit of using the 4Ms in clinical practice. See Figure 1 and slides 38-49 for more detail.

Figure 1. 4M Framework



Discussion

While reviewing the successes and challenges of implementing the 4Ms at Northwell, there was discussion of EHR-related barriers. Northwell currently has different EHRs for different settings and the time needed to review charts is burdensome. Dr. Kessler shared that, while there is technical interoperability and EHRs can be shared, EHR fields are missing, insufficiently populated, and include inaccurate data. There are limitations to patient-reported fields and metal health fields that hinder PCCP. Multiple EHRs present challenges to seamless tracking and adherence to care plan. One member reported that benefits from her state's Health Information Exchanges (HIE) are limited since HIEs do not say much about What Matters Most, functional status, or cognitive status.

Dr. Hladek noted that providers can be flagged when quality measures (e.g., A1c and BP goals) are not met, even when these goals do not align with What Matters Most to the patient.

There was a question about how Goals of Care or What Matters Most are being used or reviewed by specialists. This is an area for future research for Northwell. In the chat, someone asked whether standard of care through guideline recommendations interface with professional and patient goals of care, and how to build that in.

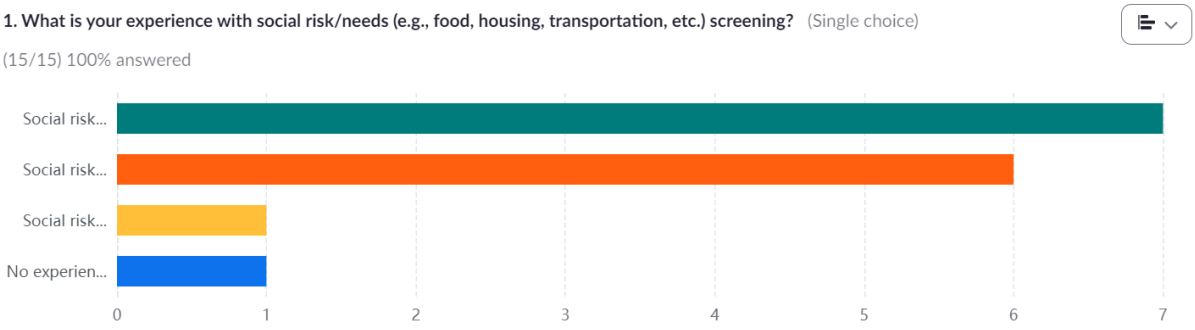
Dr. Miller queried how What Matters Most is established for patients with mentation issues at Northwell. Does the provider skip the Patient Centered Care Plan? Dr. Chudasama relayed that this may go into advanced care planning and involve a proxy. Dr. Reuben reflected that What Matters Most is equally, or possibly more, important for people with cognitive impairment. Dr. Borson raised that often there is not a decision to be made in ordinary, ongoing care, which should be distinguished from end-of-life care.

Case Study III: Considering the Social Context in Chronic Disease Primary Care

Presenter: Danielle Hessler Jones, PhD, co-Director of the Social Interventions Research and Evaluation Network (SIREN), Professor and Vice Chair for Research, Dept. of Family and Community Medicine, University of California, San Francisco

Dr. Hessler Jones described the impact social risks have on chronic disease self-management, making common health care tasks more challenging and often contributing to delayed engagement in care. Dr. Hessler Jones assessed LC members' experience with social risk screening with a poll (see Figure 2).

Figure 2. LC Member Engagement with Social Risk Screening



Options	Responses
No experience personally at my clinical setting or in my research	1/15 (7%)
Social risks/needs screening is occurring at my clinic and I am not involved	1/15 (7%)
Social risks/needs screening is occurring at my clinic and I am involved (e.g., reviewing results, discussing with patients, provid...	6/15 (40%)
Social risks/needs screening is a part of my research	7/15 (47%)

Dr Hessler Jones explored some barriers to social risk screening in primary care, including desire for assistance (i.e., patient/family acknowledging a social need that they are interested in assistance from their care team with). Dr. Hessler Jones then reviewed a case study example that illustrated how social risks can impact patient goals and require thoughtful adjustment for care planning.

Discussion

Dr. Borson shared a paper on how social risk and social needs screening produce different results, showing that providers cannot assume patients want assistance when they screen positive for a social risk.

> Winslow VA, Lindau ST, Huang ES, et al. Caring for dementia caregivers: How well does social risk screening reflect unmet needs? *J Am Geriatr Soc*. 2024; 1-11. doi:10.1111/jgs.19200

An LC member asked what to do when there are no community resources. Dr. Pederson highlighted that even then, there are assets unique to each community that can be identified, supported, and integrated into care. Dr. Hessler Jones shared the 5A's framework (awareness, assistance, adjustment, alignment, advocacy), below, which she used earlier in her presentation, as a broader guide for the health system's role.

> National Academies of Sciences, Engineering, and Medicine. 2019. Integrating social care into the delivery of health care: Moving upstream to improve the nation's health. Washington, DC: The National Academies Press. https://doi.org/10.17226/25467.

Gottlieb LM, Lindau ST, Peek ME. Why Add "Abolition" to the National Academies of Sciences, Engineering, and Medicine's Social Care Framework? AMA J Ethics. 2022 Mar 1;24(3):E170-180. doi: 10.1001/amajethics.2022.170. PMID: 35325517; PMCID: PMC9591153.

CAPABLE (https://capablenationalcenter.org/) and Neighborhood Nursing (https://nursing.jhu.edu/faculty-research/research/areas-of-expertise/community-global-health/center-community-innovation-scholarship/neighborhood-nursing/) are examples of programs that bridge social needs and build trust. Robyn Golden, LCSW, noted that social risk screening can be a valuable opportunity to intervene for folks who may fall through care gaps.

Dr. De Marchis asked if the group had experience compensating community organizations for their work. LC members reported that CBOs can have contracts with health plans, and researchers can write in funds for CBOs into proposals. Members also acknowledged the new Medicare billing code for Community Health Workers (CHWs). The Macmillan nurses in the UK were brought up as examples of additional help in the community.

Dr. Bierman noted that the Agency for Community Living (ACL) Community Care Hubs are a good model to look at. Community hubs coordinate social services and integrate with health care, https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs.

In closing, Dr. Hessler Jones noted that surveys have shown that even just asking and acknowledging needs is important to patients and may provide a benefit to patients and patient: health care team relationships. She shared SIREN's recent updated logic model for social care (https://sirenetwork.ucsf.edu/tools-resources/resources/revising-logic-model-behind-health-cares-social-care-investments).