Agency for Healthcare Research and Quality
Person-Centered Care Planning for Persons with Multiple Chronic Conditions
Summary of Learning Collaborative Session #4-5 – November 4, 2024

Facilitated by Drs. De Marchis and Miller

AHRQ Partners in Attendance: Martina Azar, PhD; Arlene Bierman MD, MS; Kisha Coa, PhD; Brenda Harding, MA

Project Team Members in Attendance: Zach Beebe, Jennifer Coury, MS; Emilia De Marchis, MD, MAS; LeAnn Michaels, BS; Lyndsey Miller, PhD; Zsolt Nagykaldi, PhD; Kate Peak, MPH

Learning Collaborative Members in Attendance:

Neeraj Arora, PhD, PCORI
Sandy Atkins, Partners in Care Foundation
Barbara Bokhour, PhD, Center for Healthcare Organization and Implementation Research
Soo Borson, MD, Keck USC School of Medicine
Cynthia Boyd, MD, MPH, Johns Hopkins Division of Geriatric Medicine and Gerontology
Edith Burns, MD, Zucker School of Medicine at Northwell
Maria Carney, MD, MACP, Northwell Health
Anna Chodos, MD, University of California San Francisco
Tom Cornwell, MD, Village Medical at Home/VillageMD
Robyn Golden, LCSW, Rush University
Maria Guyette, MD, MPPM, UPMC Health Plan
Melissa deCardi Hladek, PhD, CRNP, FNP, John Hopkins University
Vijay Kannan, MD, MPH, Indian Health Service Headquarters
Kim Kuebler, DNP, APRN, Multiple Chronic Conditions Resource Center
Aruna Nathan, MD AbsoluteCare
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
Saul Weiner, MD, University of Illinois at Chicago
Kelly Rice Williams, PhD, MPH, UPMC Center for High-Value Health Care

Learning Collaborative Members Not in Attendance:
Larissa Aviles-Santa, MD, MPH, National Institute on Minority Health and Health Disparities, **Kasey Boehmer, PhD, MPH,** Mayo Clinic, **Malaz Boustani, MD, MPH,** Indiana University, **Barrett Bowling, MD, MSPH,** Duke University, **Lenise Cummings-Vaughn, MD,** Center for Medicare and Medicaid Services, **Samuel Edwards, MD,** VA Portland Health Care System, **Omar Escontrías, DrPH, MPH,** Equity, Research & Programs National Health Council, **Jose Figueroa, MD,** Harvard University, **Jonathan Flacker, MD,** Chen Med, **Christina Frazel, MD,** Hennepin Healthcare, **Christian Furman, MD, MSPH,** University of Louisville, **Jane Jih, MD, MPH, MAS,** University of California San Francisco, **Rodger Kessler, PhD, ABPP,** University of Colorado Anschutz Medical Campus, **Alex Krist, MD, MPH,** Virginia Commonwealth University, **Elizabeth**

Kvale, MD, MSPH, VA What Matters Program, **Tracy Ellen Lippard, MD,** Kaiser Permanente, **Jessica Ma, MD,** Duke University, **Joan Monin, PhD,** Yale School of Public Health, **Ugochi Ohuabunwa, MD,** Emory University, **Julie Parker, LCMHC, CCM,** Vermont's Blueprint for Health Waterbury, **Rob Schreiber, MD,** myPlace Health, **Barbara Sullivan, BA,** Village to Village Network, **Sarah Szanton, PhD, RN,** John Hopkins School of Nursing, **Brittany Watson, MD, MPH, BSN, FAAFP,** NC Medicaid, **Jiayun Xu, PhD, RN,** Purdue University School of Nursing

Invited speaker: Saul Weiner, MD

Recording Info:
https://zoom.us/rec/share/W1Gn1LZ9zd6H8LdN0eoYEQUJQQc3EySetexBtw5UnxHXbj4qPUQtJBLbdfy1LJ9R.Ec0cJdUp2AG7og6D?startTime=1730826185000

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Meeting Summary

Overview

Dr. Emilia De Marchis and Dr. Lyndsey Anderson led the combined fourth and fifth Learning Collaborative (LC) session. The agenda included an update from Dr. Arlene Bierman, a review of LC Meeting #3, two in-depth breakout sessions on Planning and Implementing a PCCP Initiative, and a presentation by Saul Weiner, MD, on Contextualizing Care.

AHRQ Update

Dr. Arlene Bierman opened the LC meeting with several AHRQ updates. She highlighted a recent paper that identified key barriers and facilitators to implementing PCCP at scale.[1] This paper served as the impetus for this project and emphasized the need for multi-modal, multi-component, and multi-level changes. Dr. Bierman also announced three new AHRQ funding opportunities on the State-Based Healthcare Extension Service program. She noted that, although the initial focus for the state collaboratives is behavioral health, there is interest in interventions that could be transformational in nature providing whole-person, person-centered care, potential for addressing health-related social needs, and tailoring interventions across the life span. Dr. Bierman encouraged people to apply and/or determine who from their state is applying to incorporate person-centered approaches in the proposed plan. She shared a resource, the HL7® MCC eCare Plan,[2] which aggregates data from multiple sources and includes relevant information to support care planning for people with multiple chronic conditions (MCC). In addition, she referred to the ICOPE approach[3] as another model for person-centered assessment and care. Finally, Dr. Bierman shared a letter from senators King (Maine), Sanders (Vermont), and Kaine (Virginia) requesting that AHRQ study the impact of ageism on care delivery.[4]

Session #3 Recap

In the previous session, Learning Collaborative members heard from three speakers who presented different approaches to PCCP through their distinct cases studies: Collaborative Care and PEARLS (Program for Encouraging Active Rewarding Lives for Seniors), the 4Ms (Mobility, Mentation, Medication, and What Matters Most), and Social Context in chronic disease management.

Breakout Session #1: Planning an Initiative

Attendees were divided into two breakout groups of 10-14 participants. In the first session, Steps 1 (Create a sense of urgency) and 4 (Enlist the team) from Kotter's 8-step Change Model[5] were used to frame Part 1- Planning a PCCP Initiative.

Step 1: Create a sense of urgency

Why establish PCCP as an organizational priority?

Members of breakout Group 1 discussed the importance of establishing PCCP as an organizational requirement. As previously discussed, PCCP improves self-management among an expanding, expensive population, decreases hospital readmissions and improves quality of care. One member noted that healthcare systems, like businesses, are profit driven and care about payer requirements and potential competition. Therefore, PCCP implementation needs to be driven by payers or patients (customers). Already, prevention and adherence to treatment plans are part of the quality measures that affect payments. The question remains, what level of evidence is required to demonstrate PCCP as one of the most important elements for return on investment to achieve long-term cost savings?

LC members in breakout Group 2 noted that, besides improving patients' care and their experience of care, PCCP enhances providers' experience of care. In terms of organizational buy-in, PCCP will reduce fragmented, duplicative care (which saves money) with improved ways to communicate across the care continuum.

How can you gain leadership and clinician buy-in for PCCP?

In Group 1, Dr. Bierman observed that there is more than one purpose for PCCP and asked how AHRQ can align their efforts to have a bigger impact on the national level. The group suggested illustrating the evidence of PCCP's impact through case studies and aggregated case studies.

For clinician buy-in, Group 2 noted that an ideal PCCP initiative will not create more work/burden for clinicians but will distribute tasks across team members and improve satisfaction with care delivery (versus contributing to burnout). Dr. Hladek's team often works with clinicians to show how spending just 4 minutes with patients on PCCP can save time in the end, be rewarding to both patients and clinicians, and contributes to health equity and trust building. Demonstrating return on investment with a PCCP business plan that focuses on C-suite pain points and frames PCCP as a plan/solution that's beneficial to healthcare teams and patients will be important to healthcare leaders.

Step 4: Enlist the Team

Which interdisciplinary team members should be included?

Group 1 noted that determining the ideal composition of an interdisciplinary team is contextual and depends on the practice. For example, the shortage of nurses and other trained medical professionals in some practices make person-centered care planning and care coordination difficult. One participant, who works in lifestyle medicine, has found the use of apps and data collection direct from patients has changed the team needs.

Group 2 also emphasized the importance of context in forming interdisciplinary teams. Dr. Reuben noted the need for two distinct PCCP teams. The first team will get the PCCP initiative up and running and includes a senior leader - the person who can say "yes"; a mid-level administrator, who will implement PCCP and can provide a dose of reality; and the product champion(s), who keep pushing until they get to "yes." The second team will implement the program and includes care team members and community-based human and social service organization leaders. Community Care Hubs are an example of models that coordinate care and connect resources across home, community, and healthcare systems. In the VA, health and wellness coaches work with patients to identify goals and integrate them with the rest of the clinical team, including specialists.

What resources or training will prepare the team and build readiness?

Time, strong communication, and trained staff emerged as essential resources for Group 1. One member noted that administrative inertia impacts quality and safety and is also entrenched in the healthcare systems. In her work, she sees how systemic barriers to communication result in adverse events. Staff are stretched too thin, sometimes requiring temporary or on-call workforce, and move rapidly from task to task versus “owning” patient care. Overreliance on EHRs may play a role in administrative inertia. Ensuring clinicians have more time to think during patient visits is key to their exercising discriminative judgment in complex situations. Training resources may be necessary for the clinic team to train new staff due to shortages and turnover. One member noted the benefit of ongoing, continuous care team meetings to discuss issues in delivering better patient care.

Group 2 participants noted that widespread, recurring PCCP training is sorely needed. While people understand they need to ask about what matters most, they don’t know how to integrate that with the rest of a patient’s care (i.e., how to link patient care and patient goals). Role playing, studying examples, and testing it out, form an effective training method. Dr. Cornwell coaches clinicians one-on-one to conduct patient-centered conversations. CAPABLE, which promotes patients’ priorities of care, has a national training center that disseminates training as a multi-modal approach, including training students. They have a 7-week training program that occurs biannually and may offer a certificate program in the future. The VA hosts monthly Whole Health communication calls and they are evaluating clinical interactions to understand how patients perceive and rank their clinician for doing PCCP well.

Part 1: Design and Feasibility

In this portion, each group used the scenario of receiving research funding to study the implementation of PCCP for people with MCC in five primary care sites. Participants worked to define success, what success looks like from different perspectives (patients, clinical team, researchers), and how to build a productive partnership.

Over the course of the project, what do you want to learn from the clinical sites to advance our understanding of what it takes to conduct PCCP for MCC?

Members of Group 1 wanted to learn about implementation including elements that are easier to facilitate, what gets modified by site, and how EHRs facilitate PCCP goal development. In addition, learning to balance prioritization of what matters most when a patient has several conditions was requested.

Members were concerned that we overestimate the readiness of patients to develop goals of care for themselves. People with multiple chronic conditions have universal, standard goals: to be healthy (e.g., A1c at appropriate level), to be able to function, and to live their lives. It is challenging for patients to act like clinicians and weigh different goals of care and priorities, especially when they have many chronic conditions. Dr. Nathan uses motivational interviewing and time-based SMART goals to plan and track patients’ goals and how confident they feel that they can achieve them. She feels that confidence in achieving PCCP goals could be a key metric.

Lack of adequate time for clinical encounters continues to be a limitation to providing relationship-based care where providers understand their patients’ values and preferences. Systems’ supports are not in place. Additionally, members wanted to figure out how to integrate PCCP into the biomedical model framework to ensure it remains a part of care. Behavioral interventions that are implemented separately from biomedical interventions are unlikely to be used broadly in the healthcare system.

Group 2 participants noted the importance of developing formative evaluation tools to determine site-specific needs, resources, and leadership buy-in to implement PCCP. Studying and compiling examples of how PCCP works across different settings is important to develop interventions that are nimble, responsive to patients' desires, and meet clinical team members where they are. Participants are interested in relevant measures that capture person-centeredness and well-being rather than clinical outcomes. Tools to quantify intervention costs or savings, both health-centered and financial outcomes, will help build the business case for PCCP.

How will we know from a patient perspective if this (PCCP) is successful?

Group 1 members suggested objective measures like decreased risk of additional chronic conditions and decreased blood pressure; patient-reported outcome measures like improved quality of life and increased PHQ-9; as well as meaningful patient satisfaction measures.

Group 2 discussed challenges documenting success with current practices, especially when using the same measures pre- and post- intervention where a signal may be difficult to detect. One member had success talking to patients versus using surveys. Another member asks patients how they are doing now compared to before the PCCP intervention. Another member focuses on patient self-efficacy and social cognitive theory and sees benefit using a 10-item vs. 5-item response option. Others feel qualitative work and talking to patients about their experiences is a key component to include with evaluating the interventions’ impact on health care costs for patients.

What does success look like to the clinical team?

For Group 1, success would demonstrate implementation fidelity, which compares the implementation to how it was imagined and designed, using thorough evaluation of each site and every level of staff there. Successful implementation would entail readiness assessments and customized EHR infrastructure that meets the needs of each practice.

Group 2 noted that a successful intervention provides meaningful and gratifying work for care teams, distributes the work across team members, and draws more clinical teams into PCCP. Measures of success should be meaningful and integrated into existing processes to avoid provider burnout.

What does success look like to the research investigator?

Group 2 noted that, beyond meeting funder goals, success would be establishing outcomes that are measurable across the care team. Dr. Hladek offered the Measure Yourself Medical Outcome Profile (MYMOP), a symptom-based tool that provides overarching and incremental goals for symptom management and reduction. Others feel success is using goals that are co-developed with participants (care team or patients), are nimble enough to detect signal, and consider temporal needs (e.g., participants’ perceptions of goal-achievement will differ after 6 months).

How do we build productive partnerships to support practice change and meaningful evaluations?

Group 1 noted that pragmatic studies that evaluate the needs and dilemmas faced by the clinical team are critical to ensuring research benefits the care team and their patients. Supporting efforts to disseminate innovative PCCP interventions by clinician-researchers is imperative. These individuals need to safeguard time for patient care while disseminating their work. Increasing participatory design would be beneficial for clinicians and patients. Dr. Bierman observed that we need to flip the established practice of designing models for ideal settings and then adapting for sites with fewer resources—to, instead, design for low-resource from the beginning.

Breakout Session #2: Implementing an Initiative

In the second session, Kotter's 5 step, "Enable Action" framed Part 2, Implementing an Initiative.

Part 2: Implementing an Initiative

How will we coordinate and deliver person-centered care as outlined in PCCP?

Group 1 members shared several suggestions: Assess readiness to change; ensure training includes clearly defined team member roles, standard workflows, and established tracking systems for implementation, and benchmarking. Workflows should include the most used tools and support use of the reimbursement enabler. Short, medium, and long-term goals should be documented in the care plan. Short-term goals are already usually listed at the end of the visit, but they need to be then translated into a task list, establishing accountability for action steps toward long-term PCCP. Another consideration is planned adjustment of the cadence of care (e.g., how often contact is made, about what, with which provider), and through which modality (e.g., remote or in person).

Group 2 noted there are limitations communicating care goals using existing tools (e.g., through EHRs) that need to be addressed. Huddles could address communication needs, but they may be difficult to hold consistently. Including care navigators on the team, who communicate with physicians, CBOs, specialists, and establish goals, could be beneficial. Dr. Szanton is implementing "Neighborhood Nursing", a new initiative that serves the entire family system through case management and advocacy, with great success.

How will we document patient goals of care?

One member of Group 1 has seen examples in Belgium where patients' goals are documented at the top of their charts and clinicians are taught to ask themselves, "What can I do today to further the patient's goals?" EHRs have a care plan tab, but it is underutilized and does not connect with other health systems the patient may use. AHRQ designed a pair of applications: eCare Plan (care team facing) and MyCarePlanner (patient facing) to address this problem. These two applications compile comprehensive medication, lab report, and diagnosis information into one place. There are still many challenges to overcome, such as data blocking from big vendors, but the eCare Plan is a good step forward. For hospitals, including PCCP measures in CMS' Inpatient Quality Reporting (IQRs) could provide documentation and be a powerful motivator to scale PCCP.

Group 2 noted that there are limitations to communicating care goals and EHRs need better usability to track patient care goals across settings. They also noted that Epic's care planning tab is underutilized. One healthcare system is offering an incentive to a cohort of physicians' assistants to better document care goals. For improved tracking, participant goals should be updated regularly. One member suggested that patients can use myhealthpriorities.org to document their priorities, print them and bring them to appointments.

Part 3: Evaluating an Initiative

What are anticipated obstacles to implementation?

Group 2 observed that most patients are not prepared to have a conversation about their health goals. Potential approaches to address this include developing and disseminating materials and handouts that patients and their caregivers can review in advance of goal setting discussions with providers. One member noted her successful conversations begin broadly, "Let's dream together," then focuses more specifically with, "If you were having a really good day, what would you be doing and who would you be doing it with?" She also asks, "What gets in the way of that good day?"

What are anticipated facilitators to implementation?

Group 2 noted several facilitators: keeping the intervention short, spreading tasks across the team, ensuring people are working at the top of their licenses, securing administrator buy-in, and having someone to call when things get tricky. Establishing a national PCCP network of peers would be a great resource.

How would the research team systematically track PCCP implementation success?

Group 2 observed the importance of including an implementation science framework perspective, (e.g., RE-AIM). Potential metrics could include: How many patients got a personal health plan? How many providers actually looked at it? How many patients are getting it? Whether it was sustained? Whether the plans were reviewed again? A key to implementation success is knowing which strategies ensure PCCP gets used on a regular basis by examining how it is used over time and surveying providers about their experience and ability to sustain PCCP. Measures of the quality of the PCCP implementation are any area for further exploration.

Participants also spent time discussing whether PCCP has sufficient evidence of efficacy. This led to a discussion about the role of hybrid designs--looking at both effectiveness and implementation strategies, and research across a continuum. A hybrid stepped wedge and effectiveness implementation design was recommended for multi-site intervention.

What approaches can be used to integrate quality improvement or implementation science in implementing PCCP?

Group 1 noted that the challenge is adapting the model/intervention to the context of each clinic and conducting assessments before and after PCCP implementation is crucial. Prior to implementation, participants suggest using qualitative assessments of the intended users to understand pain points around PCCP and how they define workflow since everyone has competing priorities. Qualitative feedback from all involved in the PCCP process and intervention is needed. Group 1 anticipates that staff turnover, time needed to implement a new PCCP workflow, and training (time and costs) are the primary pain points.

For Group 2, this question prompted discussion about existing programs that have shown effectiveness but are struggling to achieve widespread implementation. Interventions can be innovated time and again, but the desire is to move towards scaling. How can that be done on the policy front?

For which elements might you utilize an adaptive design that allows for learning in real time while refining the intervention?

Group 1 observed that the clinic environment demands constant adaptation with new reporting requirements and clinic issues. One member recommended older, superfluous aspects of the workflow and EHR be removed as new PCCP elements are added.

Group 2 reflected that, as research models move into the “real world,” everything changes. Local politics, resources, workflow, etc., contribute to site specific adaptation issues and impact effectiveness. Participants wondered what core components of PCCP must be kept while remaining nimble and what kind of fidelity measures are being implemented and sustained. Participants felt core PCCP components include ensuring patient's values and goals are integrated into treatment decision-making though there may be a spectrum of well-being components (e.g., quality of life) to consider.

What outcomes would indicate a positive impacts for patients and families?

Group 1 members reported physical functioning, improved nutrition, increased physical activity, good social connectedness, decreased use of cigarettes and alcohol, good sleep, patient-family assessment of achieving goals, or improved quality of life could indicate positive impact for patients and families. They noted that success can be nuanced and appear as stability of outcomes and/or improvement in some areas rather than attaining all goals.

For Group 2 members, outcomes should illustrate whether patients are achieving their own goals and have overall well-being. Measuring on a scale of 1 to 5 is not person-centered enough.

How do you measure success, including important outcomes and metrics used?

Measures of success could include documentation of the person-centered care plan, assessment of how the patient felt about plan development, care satisfaction, rate of connection to services from the care plan, adherence to plan components, follow-ups, physical/functional performance, quality of life, and patient-reported outcome measures. Qualitative interview data can provide useful, contextual information.

Contextualizing Care: An Essential and Measurable Clinical Competency

Saul Weiner, MD, Deputy Director, VA Center of Innovation for Complex Chronic Healthcare; Medical Services, Jesse Brown VA Medical Center; Professor of Medicine, Pediatrics and Medical Education, University of Illinois at Chicago

Dr. Weiner gave an overview of his work with Veterans Affairs to study patient-clinician interactions using audio recordings of clinical encounters. He has identified four critical elements to any clinical encounter: Contextual Red Flag (a clue that something in the patient’s life is impacting their care), a Contextual Probe (asking patients about the issue), Contextual Factors (anything in the patient’s life impacting their care) and a Contextualized Plan of Care (adaptations based on context). To provide person-centered care, it is important for providers to understand the patient’s context and how it interacts with the patient’s ability to achieve their goals of care. Several additional examples are provided in the slide deck.

Discussion:

In response to a question about primary care physicians’ hesitation to participating, Dr. Weiner outlined the following three principals of design that he adheres to: the intervention cannot add burden, users must see the value in the intervention, and it must be safe for both clinicians and patients (e.g., individual recordings will not be shared with the physician’s boss). One limitation of contextualizing Care is that it can only address factors that patients reveal.

Other questions included: Have you investigated the economic cost of contextual errors? Has this been implemented in any PCCP models? Can this be combined with models and training of interdisciplinary teams? Contextualizing Care is a tool for measuring clinical performance and competency and can be paired with a particular model. It can also be used for training. Dr. Weiner noted that, when physicians label patients as ‘non-compliant’, they let themselves off the hook and may miss an important contextual red flag (e.g., not taking meds). With advances in AI tools, audio screenings could be done by AI but recent attempts to train AI have not gone well.

Resources

1. Barriers and facilitators to PCCP Implementation (Dr. Bierman):
   Watson BN, Estenson L, Eden AR, et al. Person-Centered Care Planning for People Living With or at Risk for Multiple Chronic Conditions. JAMA Netw Open. 2024;7(10):e2439851. doi:10.1001/jamanetworkopen.2024.39851

2. The FHIR Implementation Guide (Dr. Bierman): https://hl7.org/fhir/us/mcc/STU1/index.html

3. World Health Organization’s ICOPE (Integrated care for older people) program (Dr. Bierman):

   Citation: Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care, second edition. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO.

4. Letters to AHRQ to study ageism (Dr. Bierman):
   https://www.kaine.senate.gov/imo/media/doc/ahrq_letter.pdf

   https://www.king.senate.gov/newsroom/press-releases/king-calls-for-study-on-hidden-costs-of-ageism-on-health-care

5. Kotter, J. P. 1996. Leading change. Harvard Business School Press, Boston.