Agency for Healthcare Research and Quality
Person-Centered Care Planning for Persons with Multiple Chronic Conditions
Summary of Learning Collaborative Session #6 – January 21, 2025

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Learning Collaborative Members Not in Attendance:

Sandy Atkins, Larissa Aviles-Santa, Kasey Boehmer, Malaz Boustani, Barrett Bowling, Maria Carney, Lenise Cummings-Vaughn, Samuel Edwards, Omar Escontrías, Jose Figueroa, Jonathan Flacker, Christina Frazel, Robyn Golden, Rodger Kessler, Elizabeth Kvale, Joan Monin, Ugochi Ohuabunwa, Julie Parker, Katherine Ritchey, Rob Schreiber, Barbara Sullivan, Sarah Szanton, Kelly Rice Williams, Jiayun Xu

Meeting Summary

Welcome and Agenda Overview

Dr. Lyndsey Anderson and Dr. David Dorr led the sixth and final Learning Collaborative (LC) session.

Opening Remarks and AHRQ Updates

Dr. Arlene Bierman opened the Learning Collaborative (LC) meeting inviting participants to join the Summit March 3rd, 2025 (more information in next session). Through funding from the John A. Hartford Foundation, the PCCP4P project is sponsoring a special collection of articles highlighting Person-Centered Care Planning (PCCP) in *Learning Health Systems*[1] in January 2026. More information about submitting a Letter of Intent will be available this Spring. The Agency for Healthcare Research and Quality (AHRQ) is seeking information from the public to understand the impacts of ageism on healthcare quality. Comments must be submitted on or before March 15, 2025.[2] There are several relevant AHRQ funding opportunities available.[3] Dr. Bierman highlighted a recent paper, demonstrating interoperability among nine federal agencies[4] which outlines building blocks for unified health data exchanges. Dr. Bierman shared news that United States Core Data for Interoperability (USCDI) elevated care planning as a data element based on AHRQ's work in draft version 6, which is open for public comment until Apr 14, 2025.[5] Dr. Bierman also noted new CMS payment codes that support advanced primary care management.

Dr. Bierman gave an overview of findings from the Unmet Desire survey, which LC members contributed to last Spring. We are seeing the same themes underpin much of the work of this group and that of the environmental scans, which is that PCCP is so important. And while challenging, people continue to innovate. Better infrastructure, culture change, funding mechanisms, and robust formal collaborations are needed to solve challenges implementing PCCP. This work will be summarized soon and inform the Call to Action created after the Summit and in response to the work of this learning community's input.

Summit Introduction & Planning

All Learning Collaborative members are invited to join the PCCP4P Summit scheduled March 3rd, 2025, 8:30am – 5:00 pm, at AHRQ Headquarters in Rockville, Maryland. This event is co-sponsored by the John A. Hartford Foundation and the Patient-Centered Outcomes Research Institute (PCORI). This will be an interactive day with members from all project groups working to discuss different aspects of PCCP and develop a call to action. We hope to see you there. Please note:

- Registration begins at 7:30am with opening remarks beginning at 8:30am. It can take 30-45 minutes to get through AHRQ security – please plan to arrive by 7am
- If you have not yet RSVP'd or have any questions/concerns around travel arrangements, please email pccp4p@ohsu.edu.
- We are required to provide AHRQ with a list of attendees that will allow you to enter the building, so please let us know if you plan to join.

Environmental Rapid Scan Findings

The environmental scan team presented findings from two recent rapid scans. The first rapid scan investigated how healthcare and community-based organizations (CBOs) form partnerships to address patients' social needs. Scan #1 looked for PCCP approaches and models that explicitly connect CBOs with

healthcare organizations and which elements, functions, and structures are necessary for the delivery of PCCP to address identified social needs for people with MCC. The second rapid scan explored measures of PCCP implementation with two guiding questions: 1) what process measures have been developed or adapted specifically for PCCP implementation for people with MCC and 2) what measures specific to PCCP demonstrate effective implementation of PCCP for people with MCC (that address person-centered needs)? These findings are being drafted into a report and will be shared when they are finalized.

Healthcare-CBO Partnerships to address Social Determinants-Drivers of Health

There is minimal documentation available in peer-reviewed and grey literature on healthcare-CBO partnerships. However, there are some key examples: Community Care Hubs provide structure for CBOs and create a point of access for healthcare organizations and Area Agencies on Aging that contract with healthcare entities. There is evidence of robust contracting between healthcare organizations and CBOs. Key Informants (KIs) described challenges to partnerships between healthcare organizations and CBOs to address social needs, including a lack of willingness to collaborate and a lack of understanding around payment. Moving forward, funding, programs, policies and partnerships are critical to the successful adoption of practices that identify and address social needs in the delivery of PCCP. KIs emphasized the need for sharing success stories to grow this work.

LC members contributed their experience and several resources. Dr. Schreiber has had embedded CBO staff (e.g., social workers) in their PCMH specialty care team. In Minnesota, StratisHealth has convened CBOs, health systems and payors to co-create a referral system for social needs.

Measures of PCCP Implementation

No specific measures exist solely for PCCP, but there is alignment with the NCQA's three measures on goal setting. Four other measures [included in slide deck] showed alignment with some aspects of PCCP like shared decision-making. KIs identified factors that may impact future adoption of PCCP measures - measurement burden and time. Clinicians feel burdened by measures that require them to track everything they are doing. Moreover, this type of measurement adds documentation time.

LC members contributed their experience and several resources.[6-7] Dr. Bokhour highlighted some of the VA's work showing that patients have low expectations for PCCP, don't know what PCCP is, and often expect this is already routine when it is not. The VA recently sponsored a special issue in *Medical Care* about What Matters Most.[6] The time and administrative burden is difficult to overcome. Dr. Reuben has anecdotally seen fallout from increased administrative burden. Health systems accepted by the new CMS GUIDE program, which includes measures for patient enrollment, payment structures, and CBO partnership, are dropping out due to administrative burden. Adding even a small number of measures can be a deal breaking burden. Electronic health record systems are underdeveloped to support administrative burden and could do more. Dr. Cornwell shared a recent article NCQA authored on a core measure set for Age Friendly Health Systems that could inform future work regarding what is relevant and what is realistic.[8] Dr. Krist noted new CMS advanced primary care management payment codes could address this burden by supporting clinical roles, e.g., care managers, to develop patient-centered care plans.

There could also be a graded approach to organizational readiness. Dr. Bierman noted that this work used to seem aspirational, but there is now convergence around this effort with CMS advanced primary care planning, USCDI efforts and increased interoperability.[4] There is emerging work with the eCarePlanner (clinician-facing) and MyCarePlanner (patient-facing) apps where data is aggregated from multiple sources and patients can check and update their goals. Some systems are working to have patient/goals priorities on the first page of their EHR so they can regularly check in, every 6-months, and confirm those are still accurate with patients.

Summary of Learning Collaborative Findings

Dr. Dorr summarized the findings from this group.

Key Areas for Action:

1. **Research Priorities**

   Dr. Dorr emphasized the need to always consider how we can do this work in a better way and in a way that is scalable and implementable across different sites. The learning collaborative has identified implementation science approaches to inform enhanced use of existing and emerging PCCP models by looking to implementation and change frameworks. These can include agile design principles and PDSA (Plan, Do, Study, Adapt) cycles to evaluate and iterate as implementation occurs. There are notable limitations in the current evidence base around conducting PCCP with a health equity lens. More work is needed to ensure we focus on measuring what matters to patients.

2. **Quality Measures**

   Across the project, members have emphasized the need for quality measures that emphasize relationships, measures goals and their impact, what is important to the patient and continuity of care. The members have recommended measures and approaches that reward or recognize local innovation.

3. **Payment and Resources**

   PCCP is going to require funding, collaboration and scaffolding. How can we build on the existing elements of payment to make something that works, noting that it will need to adapt by context? The environmental scan identified a number of successful models that can be built on and adapted from. Additionally, there is progress in digital health (e.g., eCarePlan, health information exchanges) and opportunity for growth. Resources and partnership are required to address social needs of persons with MCC and social risks.

4. **Workforce**

   Healthcare delivery cannot change without training and skills building. Workforce training and education on PCCP are needed across multidisciplinary care teams, including an emphasis on residents, through competencies and for new learners. Professional organizations can support delivery of workforce training.

   Finally, training investments in how to do multidisciplinary team-based care and care coordination were discussed as key to adoption and scale.

5. **Local Context**

   It is crucial to consider who will be served by changes to care delivery at this time and how to meet patients where they are. There have been culture changes for healthcare providers, exacerbated by the pandemic, and increased provider burnout, while trying to deliver high-quality care in challenging environments.

Recap of Session 4-5

In the previous session, on Nov. 5th, 2024, learning collaborative participants discussed their experiences with planning, implementing, and monitoring/evaluating practice change. The group participated in breakout sessions on how to plan and launch a multidisciplinary PCCP initiative guided by Kotter's 8-step model. The group discussed why PCCP would be an organizational priority and how to gain buy-in, then

described who would be included in an ideal PCCP team and how to build readiness, design and feasibility, and what successful initiatives look. See slides 70-74 for more detail.

LC members noted that PCCP needs to be baked into all components of care delivery, from leadership buy-in to scheduling. Some aspects that have received less attention in our conversations are patient engagement as well as administrators' perspectives, who often hear directly from patients or family members. Engaging patients in implementation planning may ensure better care engagement. They can provide input on PCCP process information (written, video) and why we might be asking them about their goals to be prepared before engaging in the process with the care team. Patient goals/priorities are dynamic and may include social needs, resolving temporary pain or minimizing time spent interacting with the healthcare system.

Measures need to be flexible, brief, and adaptive to the environment to enhance flow of care. For example, when central scheduling was implemented, it reduced wait times but sent patients to providers at different locations that were unfamiliar to the patient rather than prioritizing the relationship with the primary care clinician. To reduce administrative burden, measures can be developed to serve multiple purposes.

LeAnn Michaels collated resources exchanged over the course of the project Summary of Resources.

Closing

The project team extends their gratitude to LC participants for their time and engagement over the course of this project.

Resources

1. Learning Health Systems: https://onlinelibrary.wiley.com/journal/23796146
2. AHRQ Request for information on the impact of ageism in healthcare, comments due March 15th, 2025: www.federalregister.gov/documents/2024/12/27/2024-31074/request-for-information-regarding-the-impact-of-ageism-in-healthcare
3. AHRQ Funding Opportunities

    AHRQ Announces Interest in Health Services Research to Reduce Emergency Department Boarding and Hospital Crowding

    AHRQ Announces Interest in Research to Improve Treatment and Management of Menopause Symptoms

    AHRQ Announces Interest in Health Services Research to Improve Care Delivery, Access, Quality, Equity, and Health Outcomes for Older Adults

    AHRQ Announces Interest in Health Services Research to Improve Healthcare for Persons Living with Disabilities

    AHRQ Announces Interest in Health Services Research to Advance Health and Healthcare Equity

    Advancing the Collection and Use of Patient-Reported Outcomes and Patient Contextual Data to Improve Quality and Outcomes in Ambulatory Care through Health Information Technology

    AHRQ Announces Interest in Primary Care Research

4. A Unified Approach to Health Data Exchange: A Report From the US DHHS https://jamanetwork.com/journals/jama/fullarticle/2829545
5. USCDI Draft 6 available for comment until April 14th, 2025: https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi#draft-uscdi-v6
6. Special Issue in Medical Care, Dec 2024, sponsored by the VA on Measuring What Matters Most https://journals.lww.com/lww-medicalcare/fulltext/2024/12001/measuring_what_matters_most__considering_the.2.aspx
7. https://www.healthaffairs.org/content/forefront/innovation-cms-advancing-person-centered-health-system
8. https://www.healthaffairs.org/content/forefront/core-measure-set-age-friendly-health-care-delivery