

November 15, 2022

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Office of the Director
Agency for Healthcare Research and Quality
US Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

RE: AGS Comments on Request for Information (RFI) on Person-Centered Care Planning for Multiple Chronic Conditions (MCC)

Dear Director Valdez:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments on comprehensive, longitudinal, person-centered care planning for people with Multiple Chronic Conditions (MCC) across settings of care (e.g., health systems, primary care, home, and other ambulatory practices), including innovative models and promising solutions. Founded in 1942, the American Geriatrics Society (AGS) is a nationwide, not-for-profit society of geriatrics healthcare professionals dedicated to improving the health, independence, and quality of life of older people. Our nearly 6,000 members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, internists, nurses, physician assistants, and pharmacists who are pioneers in advanced-illness care for older adults, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. The AGS believes in a just society, one where we all are supported by and able to contribute to communities where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. The AGS advocates for policies and programs that support the health, independence, and quality of life of all of us as we age.

We have responded to a number of the questions in the RFI below.

(2) What key components are necessary to fully deliver on the promise of person-centered care planning?

In 2015, with funding from the SCAN Foundation, an AGS expert panel defined person-centered care in a paper published in the *Journal of the American Geriatrics Society (JAGS)* as follows: “person-centered care” means that individuals’ values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all

relevant providers.” This collaboration informs decision-making to the extent that the individual desires.¹ The expert panel specified that the following elements are essential to achieving this definition:

- (1) An individualized, goal-oriented care plan based on the person's preferences.
- (2) Ongoing review of the person's goals and care plan.
- (3) Care supported by an interprofessional team in which the person is an integral team member.
- (4) One primary or lead point of contact on the healthcare team.
- (5) Active coordination among all healthcare and supportive service providers.
- (6) Continual information sharing and integrated communication.
- (7) Education and training for providers and, when appropriate, the person and those important to the person.
- (8) Performance measurement and quality improvement using feedback from the person and caregivers.

There are many barriers to implementing the comprehensive approach outlined by the expert panel. These include the fragmented nature of the fee-for-service health care system, lack of payment for this type of care, and lack of ways to measure the quality of such care when it is provided given our disease-based quality measurement system.

In 2017, the AGS convened an expert panel to review successful geriatrics models of care and identify the common elements of that care. In a paper published in *JAGS*,² the expert panel, echoing the earlier panel, defined person-centered care as an individualized care plan that reflects an individual's unique preferences and empowers patients to actively participate in their care. They found that the three most common elements of successful geriatrics care models were: person-centered care, interdisciplinary team (IDT) assessments, and complex care management.

The AGS believes, given the heterogeneity of the older adults, integrating person-centered care planning into the care that older adults receive is essential to optimizing our health as we age.

(3) How is comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC currently being done in health systems, primary care, and other ambulatory practices?

One promising model was pioneered by the Dartmouth Centers for Health and Aging Geriatrics Workforce Enhancement Program (GWEP) funded by the Health Resources and Services Administration (HRSA). *Geriatrics Interprofessional Team Transformation – Primary Care (GITT-PC)*³ focuses on a workforce culture change to empower primary care teams to achieve best practice in geriatrics in primary care. This program, using a person-centered approach, is focused on how patients can help

¹ American Geriatrics Society Expert Panel on Person-Centered Care. Person-Centered Care: A Definition and Essential Elements. *J Am Geriatr Soc.* 2016;64(1):15-8. [doi:10.1111/jgs.13866](https://doi.org/10.1111/jgs.13866)

² McNabney, MK, Green, AR, Burke, M, et al. Complexities of care: Common components of models of care in geriatrics. *J Am Geriatr Soc.* 2022; 70(7): 1960- 1972. [doi:10.1111/jgs.17811](https://doi.org/10.1111/jgs.17811)

³ Bartels SJ, Flaherty E, Tumosa N. The new geriatric interprofessional team transformation in primary care: an implementation science approach. *Innovation in Aging.* 2018;2(1):30. [doi:10.1093/geroni/igy023.111](https://doi.org/10.1093/geroni/igy023.111)

transform the work of all team members in primary care including medical assistants, nurses, advanced practice clinicians, physicians, office managers, and support staff. The process of team transformation begins with specific team member assessments and readiness tools. Traditional content including effective communication, roles on teams, conflict resolution, and care planning is delivered in the context of team implementation of Medicare reimbursable primary care services including Annual Wellness Visits, Chronic Care Management, Advance Care Planning, and Dementia Care. The benefit for both the patient and the practice is the implementation of the following four core components of evidence-based geriatrics care: Annual Wellness Visits, Transitional Care Management, Chronic Care Management, and Advanced Care Planning.

4. Which organizations are successfully engaged in person-centered care planning for people at risk for or living with MCC?

In 2017, The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and Catholic Health Association of the United States (CHA), began to build the Age-Friendly Health System movement which entails providing care that aligns with What Matters to the older adults and their family. Age-Friendly Health Systems means that a system is reliably providing a set of four evidence-based elements of high-quality care, known as the “4Ms,” to all older adults in that system. The 4Ms are: What **M**atters, **M**edication, **M**obility, and **M**entation. The cornerstone principles of age-friendly care are:

- (1) Follow an essential set of evidence-based practices.
- (2) Cause no harm.
- (3) Align with What Matters to the older adult and their family caregivers.

Of note, all 48 current HRSA-funded GWEPs have been focused on integrating the 4Ms into primary care practice. Collectively, the GWEPs have partnered with 255 practices that have been designated level one age-friendly health systems and with 125 practices that have reached level two. Level two designation is predicated upon reliability delivering 4Ms care to all older adults in a health system or practice.

6. What are examples of innovative models of care, approaches, promising strategies and solutions that could support clinicians and practices in routinely engaging in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC?

Person-centered care puts personal values and preferences at the forefront of decision-making. Though critically important to the quality of care, eliciting and documenting personal values remains uncommon in routine older adult care, particularly for people with multiple health concerns that complicate pinpointing broader health priorities.⁴ Making person-centered care a reality for older adults with complex care needs takes time and effort. Where GITT-PC (see question 2) and the Age-Friendly Health Systems movement (see question 3) embed person-centered care planning as an essential element of care for complex older adults.

⁴ American Geriatrics Society Expert Panel on Person-Centered Care. Person-Centered Care: A definition and essential elements. *J Am Geriatr Soc.* 2016;64(1):15-18. [doi:10.1111/jgs.13866](https://doi.org/10.1111/jgs.13866)

Patient Priorities Care (PPC) is an approach to health care that helps older people and clinicians focus decision-making on patients' health priorities, defined as both their health outcome goals—what they want from their healthcare and their healthcare preferences—and the healthcare activities they are able and willing to do. A feasibility study that took place at a primary care and cardiology practice in central Connecticut found that PPC can be integrated into a real-world clinical practice.⁵ In comparison to similar patients receiving usual care, patients who received care aligned with their specific health priorities had more unwanted medication stopped and unwanted (and unhelpful) diagnostic testing, and procedures avoided; they also reported a reduction in the treatment burden of their care. PPC is a patient-centered approach to reducing costs.

12. What quality of care measurements (e.g., metrics, indicators) exist or are emerging for assessing process, implementation, and outcomes associated with person-centered care planning?

In order to expand on and facilitate the use of PPC and other similar programs and approaches, the AGS strongly encourages the development and deployment of quality metrics related to patient goals and treatment burden. Medicare should eliminate the use of disease-specific quality metrics for Medicare beneficiaries with multiple chronic diseases and/or conditions. Further, Medicare should align payment codes with provision of longitudinal patient priorities aligned care and require Medicare Advantage programs to identify and align care with a person's health goals for their care.

15. What credentials and/or training of the team members, including paraprofessionals such as community health workers and/or persons with lived experience such as peer recovery specialists are necessary?

Training in person-centered care planning should be a required component of training to prepare the entire health professional workforce to care for older adults with multiple complex and/or chronic conditions. Funded by HRSA, the GWEP and Geriatrics Academic Career Award (GACA) program support training and education for a wide range of health professionals, direct care workers, and family caregivers. The GWEPs partner with primary care practices and community organizations with the goal of ensuring that every member of the health care team has the skills, competence, and knowledge to care for older adults with multiple chronic conditions. As noted in question 4 above, the GWEPs have focused on the 4Ms of age-friendly care with explicit attention to ensuring that the workforce is focused on the outcomes that matter to the person. Given the paucity of health professionals with training in geriatrics, it is critical that we expand support for programs like the GWEPs and the GACAs as they are the only federally funded program that is focused on ensuring that the healthcare workforce is prepared to meet the needs of diverse older Americans, many of whom have multiple chronic conditions.

GWEPs and GACAs could play an expanded role in training community health workers and peer resource professionals to assist with person-centered care planning. There would need to be some consideration of what the core elements of such a program should be. Further, community health workers, paraprofessionals, and peer resource professionals would need to be better integrated into the team which would likely require annual training focused on the definition of patient centered care, including the challenges and ways in which to overcome those challenges (e.g., how to meet person centered preferences that may be different across roommates).

⁵ Blaum CS, Rosen J, Naik AD, et al. Feasibility of Implementing Patient Priorities Care for Older Adults with Multiple Chronic Conditions. *J Am Geriatr Soc.* 2018;66(10):2009–2016. [doi:10.1111/jgs.15465](https://doi.org/10.1111/jgs.15465)

16. Are there or should there be competency requirements for people engaged in facilitating person-centered planning processes, and what should those entail?

Although the AGS has contributed to the definition of person-centered care and essential elements that would ideally be present to achieve that definition, we believe it would be premature to establish competency requirements given the overall lack of required training in caring for older adults—specifically those with multiple chronic conditions—that exists across healthcare training. We encourage Agency for Healthcare Research and Quality (AHRQ) to ensure that attention to person-centered care planning is included in the report being prepared by the Office of the Assistant Secretary for Health (OASH) as an essential component of a strengthening primary care. We also encourage AHRQ to undertake a review of discipline-specific competencies and milestones as an essential first step to understanding what required competencies already exist in health professional training. The reality is that patients with MCC will have a spectrum of concerns which means that competencies would need to be broad and likely hard to standardize across health professions. Understanding what is already required by each discipline is foundational to determining a path forward on the development of required competencies.

17. What are suggested methods for recruiting and retaining the workforce to staff such programs?

Recruitment efforts should focus on engaging students in longitudinal experiences throughout their training so that they learn the value and benefits of providing person-centered care. Positive reinforcement and rewards can be utilized. There should also be resources and opportunities available to support clinicians to provide person-centered care (e.g., time to interact with long-term care and assisted living residents and find out their preferences).

Additionally, efforts to retaining workforce staff is likely to be improved with team-based models of care and models of care that provide continuity between levels of care. Retention is likely also improved in settings that allow flexibility and continuing education components to staff.

Recruitment and retention of staff as well as lack of training can be barriers to the delivery of person-centered care.⁶ Austrom et al. developed a promising model where care coordinator assistants (CCAs) were recruited and trained in person-centered care to ensure the CCAs had "the core interpersonal and analytical qualities required to provide excellent person-centered care." They found that the model addressed some of the issues with the recruitment, selection, training, as well as continued development of CCAs. Given that teams-based approach was central to their model in the education of person-centered care, all didactics, simulation, and clinical immersion sessions included entire teams.⁷ After the CCAs were hired, they took a 10-day training program that would support them in delivering person-centered care within a multi-disciplinary care team.

18. What are the impacts of different models of person-centered care planning on the experience of clinicians and other healthcare personnel, and are increased demands posed by some models precipitating practitioner burnout?

⁶ Low LF, White F, Jeon YH. Desired characteristics and outcomes of community care services for persons with dementia: What is important according to clients, service providers and policy? *Australasian Journal on Ageing*. 2013;32:91–96. doi:10.1111/j.1741-6612.2012.00625.x

⁷ Austrom MG, Carvell CA, Alder CA, Gao S, Boustani M, LaMantia M. Workforce development to provide person-centered care. *Aging Ment Health*. 2018;20(8):781-792. doi:10.1080/13607863.2015.1119802

In long-term care, person-centered care planning and implementation can be challenging and stressful for clinicians as there can be a tension between an older adult's preferences and their safety. An example of this is the resident that prefers to spend time alone in their room and who is also prone to falls. One outcome of creating a personal care plan that supports this preference is more frequent falls. These can lead to a clinician feeling personally responsible for not preventing the falls and reduce time spent caring for other members of the community. Such a situation often results in frustration and contributes to feeling burned out. Conversely, providing person-centered care can be wonderful in situations where flexibility allows for meeting residents' preferences (e.g., being able to eat breakfast at 11 am and sleep in every morning).

If models of care incorporate teamwork, clinicians are less likely to feel burned out. To help support practitioners, a network of individuals contributing to the same objectives but in different settings or different perspectives can be significantly additive.

From a pharmacy perspective, it can be challenging for those working in the community to have little contact or continuity from others on a care team. Many pharmacies may not choose to engage if they do not know who can support the older adult after they leave the pharmacy. Knowing that you have a team of people to contact may help a practitioner engage in new models of care and help support their purpose of person-centered care. Additionally, pharmacist-specific burnout is often seen when metrics focus on monetary or number-based outcomes as opposed to patient or quality-centered outcomes.

19. How have shared electronic care plans (e-care plans) been developed, implemented, and shared with the care team? What are best practices for sharing e-care plans across sites and settings of care?

Historically, electronic health records (EHR) and electronic medical records (EMR) have been built around supporting clinicians, practices, and systems to bill for the care that they provide and not to support person-centered care. One bright light is that in the past decade, the major EHR companies (Cerner and Epic) have launched patient portals that hold promise for more actively engaging people in their own care and for interoperability between different systems. At the same time, patient portals share many of the same characteristics of the clinician facing EHR/EMR in how they are based which can be, at best, confusing to the patient and, at worst, not conducive to implementing and managing a personalized care plan with its multiple components and team members.

An additional barrier to full integration of the different systems is that there is currently no federally supported universal identification that would follow a person across care (inclusive of biometrics). In our fragmented healthcare system, this means that older adults may have multiple records across multiple sites of care that are not connected and therefore do not provide a holistic picture of that person's health and their care preferences. For older adults with three or more chronic conditions, this only further exacerbates the barriers to providing comprehensive, holistic care that takes into account personal preferences and goals by putting the person at the center of the care team.

Unfortunately, federal and state funding over the past decade has been weighted towards supporting adoption by hospitals and health systems of EHRs. This has resulted in hospitals and health systems being able to work with EHR/EMR vendors to customize the EHR/EMR for the needs of their hospital/system. Such customization can include customizing workflows, adding alerts specific to the priorities of that system, and programming of diagnostic and other tools and resources. The end result

has been a two-tier system of EHR/EMR – one where nursing homes and assisted living locations do not have the federal subsidies to keep pace with tertiary settings of care.

One example of a workaround is the innovative use of the Advance Care Planning functionality of the Cleveland Clinic EMR who are actively engaged in implementing PPC and being mentored by National PPC Leadership including at Yale, Mount Sinai, and Baylor. The PPC plans which are longitudinal, patient centric, and focused on MCC are electronically housed in the “Advance Care Planning” (ACP) section of the electronic medical record EMR. This ACP EMR section is accessible by both clinicians and PPC facilitators (including care coordinators and population health navigators) across the care continuum. These “Integrated Care Plans” (ICPs) have complete support of the Cleveland Clinic Leadership, including the Accountable Care Organization (ACO), and are regularly reviewed for quality control and continuous refinement.

Examples of best practices steps that could be taken that would create EHR/EMR systems that would support e-care plans across sites and settings of care are:

- Address contractual agreements proactively and systematically across providers to allow a common ground amongst providers, suggesting a need for safe harbors to support interoperability.
- Adoption of Fast Healthcare Interoperability Resources (FHIR) or similar systematic methods of communication is necessary to continue the mapping out the flow of information.
- A global mapping of all information to support discrete pieces of information is necessary. For example, federal and state consistent paper or electronic forms for communication for any aspect of care amongst payers, pharmacies, clinical providers, clinical administrators, police, fire departments, emergency services, and police departments. Another example is an emergency team that may respond to a fall, but their encounter does not inform future clinical providers of the event.
- Adoption of clinical pathways where a team approach is supported across the continuum of care with permission to identify priorities and to address any aspect of the 4Ms (What Matters Most, Mobility, Medications, Mentation).
- Adoption of systematic methods for education that is based on evidence and linked to local resources to address diet, activity, socializing, and psychiatric or behavioral health service care. Education needs to be consistent across providers the patient works with.

20. What existing and emerging data standards are effectively supporting the interoperability of e-care plans? What key standards gaps around e-care plans should be prioritized by industry and other stakeholders?

A significant barrier to being able to seamlessly share e-care plans across settings of care is the lack of interoperability of EHR/EMR systems. Examples of data standards that are being implemented that would support greater EHR/EMR interoperability include:

- FHIR ([HL7.FHIR.US.CORE\Home - FHIR v4.0.1](https://hl7.org/fhir/US/CORE/Home))
- National Institute for Standards and Technology (NIST), device interoperability, and cyber security

An additional challenge is the lack of a common approach to the presentation of e-care plans in the EHR/EMR as well as ensuring that a patient and their responsible caregivers have access to the care plan as well.

One important foundational step for supporting person-centered e-care plans is to develop a common framework for how to store health care data. The AGS recommends that consideration be given to the following when developing such a framework:

- Development and use of repositories or health exchanges listing advance care plan (power of attorney for health), Physician Orders for Life-Sustaining Treatment (POLST) Medical Orders for Life-Sustaining Treatment (MOLST), immunizations at commercial pharmacies, pharmacies that serve nursing homes, pharmacies servicing hospitals or long-term facilities, and pharmacies that service assisted living.
- Indications and use of antipsychotics, anticoagulants, or neuroleptics.
- Promotions of ambulation.
- Promotion of bone health.
- Automation on meeting pharmacies or payers' requirements related to medications or durable medical equipment without an ask from a clinical provider to validate a patient demographic information (such as address) or to work outside their EHR.
- Adoption of Geographic Information Systems to map where a patient is and validating that the plan of care matches the patient condition-location, matched with problem-based documentation.

21. What policy levers should HHS use to further advance the adoption of standards-based care plans?

The AGS believes that the most important levers that HHS has at its disposal are: (1) ensuring that payment is aligned with the complexity of the care that is being provided and (2) creating and adopting a more holistic approach to quality measurement in older adults with multiple chronic conditions that does not rely on single disease payments. Elements of such a system could be modeled upon the 4Ms of age-friendly care with an emphasis on what matters to the person.

Allocating HHS funding for Health Information Technology (HIT) development that is shared as an open-source code or detailed blueprint on developing 4M pathways may support interoperability across US providers of clinical care. Further, using e-care plans to facilitate communication among people at risk for or living with MCC, their caregivers, clinicians, and health care teams, would support the implementation of the 4Ms in health systems.

22. How can technical approaches using Fast Healthcare Interoperability Resources (FHIR) standards better support sharing of e-care plans across care teams? What are major barriers to advancing these approaches?

We can better support sharing of e-care plans across care teams using FHIR by:

- Providing updates on services provided, such as discontinuation of medications (updating all providers, pharmacies, payers, patient portals, health exchanges).
- Continuing the discussion on what to include in FHIR as technology, economics, law, regulation shift due to clinical or financial pressures.

- Adding layers that capture the patient function (geriatric comprehensive assessment) leading to a proactive understanding on what may be the best location of care for a patient, especially after a hospital admission.

The major barrier to advancing technical approaches using FHIR is lack of widespread awareness among health systems regarding the full potential of FHIR to support e-care plan sharing beyond encouragement of its adoption by CMS. More specific barriers include:

- Standards are available on communication (FHIR) but not all users adopt them (health systems that are hospital centric in internal or external funding, nursing homes, assisted living).
- Lack of national repository of established workflows to address the 4Ms with instructions on how to adopt them in an EHR and matching evidenced-based interventions.
- Interoperability built in an EHR does require ongoing updates or maintenance.

23. What are best practices for using e-care plans to facilitate communication among people at risk for or living with MCC, their caregivers, clinicians, and health care teams, and provide a shared resource for documenting goals, treatments and supports, education and self-management, along with other patient-generated health data?

E-care plans that are based on PPC would most optimally capture patient priorities, values, goals, and care preferences with an authentic perspective of the patient allowing for a “living” care construct that can be dynamically updated based on the most current patient priorities with changing clinical and social circumstances. To facilitate the optimal capture of what matters most to patients, we recommend ensuring universal ease and understanding as well as accessibility of e-care plans for all stakeholders by providing resources at a third-grade level language and in the language the patient understands and only including necessary information that is succinct and readable with clear headings and sections. This should include a) patient values, goals, care preferences; b) emergency care plans for likely clinical scenarios that are high risk triggers for Emergency Department transfer or hospitalization; c) emergency contact information for both caregivers and clinical care team members; and d) social determinants of health (SDOH) limitations or nuances.

The AGS believes that the e-care plans should be regularly reviewed by a steering committee to ensure that the quality standards established for the e-care plans are sustainable, including metrics of quality of care that reflects the patient’s prognosis that is aligned with what matters to the patient and what is known clinically, as possible. As a part of ensuring sustainability, it would be important to develop, communicate, and update plans of care with consults, labs, studies, or other action items, informed in the frame of a continuum of care as compared to episodes of care. Supporting and developing e-care or e-consults may help speed up assessments that are captured in e-care plans.

The plan of care should follow the patient as they move from clinical provider to clinical provider. Concomitantly, patients, caregivers, and any member of the patient’s clinical care team should be able to make regular updates to the e-care plan with an ability for patient generated health data, including remote monitoring-based data, to flow back seamlessly and electronically into the e-care plan informing regular e-care plan updates. Caregivers are an integral member of a patient’s care team and should be recognized as such. Supporting patients and their caregivers may include identifying risk factors and proactively providing education and resources.

In addition, to protect e-care plans and maintain Health Insurance Portability and Accountability Act (HIPAA) compliance standards, there should be adequate cybersecurity as well as safeguards in place to ensure that only caregivers with healthcare power of attorney or are legally authorized have access to and ability to update the e-care plan.

24. What are promising approaches for systematically identifying and addressing social determinants of health?

In general, promising approaches for systematically identifying and addressing social determinants of health may include:

- Asking and recording patient SDOH
- Adoptions of frailty screens such as the Tilburg that include SDOH
- Develop and adopt patient portal-based surveys to capture SDOH matched with potential remedies
- Considering use of personalized apps, with patient permission, to automate capture of aspects of SDOH
- Funding GIS technology to map SDOH, matched with local resources close to the patient
- With patient permission to exchange across health care systems or other entities patient information

One innovative approach is the Cleveland Clinic Age Friendly 4M Electronic Health Dashboard (“AF4MD”). This recently developed technology solution allows for clinicians to hone in on zip codes with the highest Area Deprivation Index (ADI) to identify MCC patients with social determinant of health and 4M (as specified by Age Friendly Health Systems) clinical care gaps. The MCC older patients with SDOH and 4M needs are then linked to both 4M-focused geriatrics clinical care teams and community organizations focused on addressing social determinants of health, co-located on a unified flagship Cleveland Clinic Successful Aging care delivery platform.

Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.