

November 15, 2022

Dr. Robert Otto Valdez, Ph.D., M.H.S.A.
Director
Agency for Healthcare Research and Quality
5600 Fishers Lane
Rockville, MD 20857

Re: Request for Information on Person-Centered Care Planning for Multiple Chronic Conditions

Dear Dr. Valdez:

On behalf of the American College of Physicians (ACP), I am pleased to share our response to the Agency for Healthcare Research and Quality's (AHRQ) Person-Centered Care Planning for Multiple Chronic Conditions (MCC) Request for Information (RFI). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 160,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP greatly appreciates the opportunity to inform AHRQ's efforts to identify potential opportunities for improvement and increased efficiencies across policies, programs, and practices. We recognize that fragmented care arises when different healthcare professionals and/or organizations do not effectively work together, thereby resulting in each individual working in silo. Considering these complexities, the College has established principles and recommendations that address effective, longitudinal care, and foster ongoing primary and specialty care coordination and collaboration.

To ensure delivery of patient-centered care, the payment delivery system, and the practice of medicine itself, must establish processes which minimize fragmentation and optimize coordination of care between primary care (PC) and specialty care (SC) teams. The College has developed the following guiding principles for coordinating the care of patients with MCC.

- Principle 1: Patient and Family Partnering
- Principle 2: Defined Clinical Roles and Responsibilities
- Principle 3: Timely, Productive Communication
- Principle 4: Effective Data Sharing
- Principle 5: Reforming Physician Payment

To offer feedback in a concise manner, we have provided specific comments based on these principles and recommendations.

Principle 1: Patient and Family Partnering

Clinical care teams must work collaboratively with patients, families, and caregivers to empower them to be active partners in all aspects of care. Patient and family needs, preferences, and limitations should be actively anticipated, solicited, and considered in all care encounters and decisions. Patients and families should additionally feel empowered to be active partners in their own care but should not be responsible for the coordination of care between their PC and SC teams. Clinical teams should also incorporate patient input into all medical decision making, including but not limited to those about initial specialty care referrals and ongoing engagement. Clinicians engaging one another, the patient/caregiver, and the family in shared decision making is critical to achieving positive health outcomes.

Inadequate assessment of patient needs, values, preferences, and the failure to engage patients and families in care discussions are another set of common challenges negatively affecting patients' abilities to navigate their care. A critical element in addressing these challenges is the ability for the patient/caregiver and their families to receive an individualized referral and/or transition plan designed in partnership with the patient and family, along with copies of any other important information. The below details a practical application to a real-life scenario.

Patient moves to new town – new clinician does not have records – patient needs refills and is having issues but needs to send a record request for medical records.

“Patient and Family Partnering” approach

Ensure that the patient/caregiver receives a copy of the transfer summary to take with them. The patient/caregiver can share the transfer summary with other clinicians for any interim care, such as an acute issue requiring urgent or emergency care and subsequently provide a copy to new (receiving) clinician.

There must also be shared expectations that the patient/caregiver and/or family should ensure that the sending practice is aware of the upcoming transfer to another similar practice in advance of the time to transfer. The sending clinician should provide a copy of the transfer summary to the patient. In this instance, a helpful activity would be to prepare the transfer summary, prescriptions, and refills during a clinic/office visit (e.g., the final clinic visit), allocating time designated specifically to this task, which must be reimbursable for the clinician.

Principle 2: Defined Clinical Roles and Responsibilities

PC and SC clinicians who share patients simply cannot work in silos. It is critical that all clinicians have a shared understanding of each other's role in care, acknowledging a shared goal of well-coordinated, high-quality patient care, and proceed with mutual respect for key aspects of relationships that support the highest level of coordination. A crucial step in this process is the creation of a transition plan, and related documents, with the patient/family during an office/clinic visit devoted to the transition of care. ACP's [High Value Care Coordination \(HVCC\) tool kit](#) defines these expectations and provides critical elements for a high value referral process. The roles, responsibilities, and mutual expectations of PC and SC team members should also be clear and acceptable to all parties, including the patient/caregiver and family.

Shared expectations should include:

- The primary care team serving as the “hub” or central organizer of a patient’s overall care.
- A collaborative approach between PC, SC, and patients/caregivers which determines the appropriate level of specialty care involvement and changes over time.
- An understanding by each party of what the specialty role entails, and which clinician and care team is responsible for what aspects of care.

ACP also submitted to the PTAC, which was subsequently approved by the Secretary, a [Medical Neighborhood Model](#) (MNM) that outlines how primary and specialty care roles should interact when referrals are necessary. A few integral aspects include the following.

- With the initial referral request, primary care clinicians should include a request for the desired type of specialty care role.
- If the specialty care clinician feels that another team member would be more appropriate to help address or manage the condition, then further discussion among all parties should establish the appropriate role and responsibilities.
- As the patient and/or their condition or circumstances change, the roles and responsibilities of the different parties involved in their care may need to be readjusted as well.

Having common, agreed-upon principles and expectations for who does what in each type of care relationship establishes a foundation for reducing ambiguity and providing coordinated care for the patient. This collaboration will require a new way of approaching clinical responsibilities, one that recognizes that different clinicians will assume principal responsibility for specific elements of a patient’s care. Simultaneously, specialty and primary care should prioritize working together to coordinate care and avoid redundancy to ensure all patient needs are met. Critical elements of this type of care require the following.

- Standing care coordination agreements (CCA) which describe defined roles, responsibilities, communication, and data sharing protocols. These should ideally be at the system level (or practice-to-practice level).
- An internal plan and defined team members for all clinical and care coordination tasks. Having defined responsibilities should include assignment of who will do referral tracking and who will serve as the contact person for outside care teams, identification of the care coordinator and patient navigator, etc.

In this context, the below illustrates a practical application to real life scenarios:

Primary care clinicians frustrated - can’t get sick patients with IBD, ESLD etc. into GI care while GI clinicians continue to follow patients stable on Proton Pump Inhibitors (PPIs) - GI clinicians frustrated that PC clinicians won’t follow patients stable on PPI.

“Defined Clinical Roles and Responsibilities” approach

The preference of the PC clinician/care team is to resume management of the referred condition once stable or to have care remain with specialty care, should this be communicated at the time of the initial referral. If a condition has been co-managed long-term by SC with no prior indication regarding the preference of PC, then any party

(patient/family, PC clinician, or SC clinician) can suggest transition of management back to primary care.

Helpful elements of the ‘Defined Clinical Roles and Responsibilities’ would include establishing mechanisms for the transition and incorporation into technology. For example, dropdown options built into the EHR referral request form could include:

- “I am referring the patient for principal co-management of this condition.”
- “I prefer to resume management of this condition once stable.”
- “I prefer that you assume ongoing co-management of this condition.”

Principle 3: Timely, Productive Communication

Communication includes information exchange, but communication is more than just information exchange — genuine dialogue is also necessary. All parties should engage in timely, informative, and focused communication that highlights critical issues and/or items needing action. Communication is critical during ongoing care relationships, and several critical time points are noted by PC and SC as to when gaps in communication most commonly occur and thereby have an adverse effect. Critical time points for communication occur when a PC clinician needs feedback on concerning findings and clarity around the necessity and urgency of a referral. This also includes the initial SC evaluation when the PC clinician needs to hear back promptly regarding the diagnosis and treatment plan, along with the patient/caregiver and family response. An advanced stage of an illness also presents as a critical time point, particularly when palliative or end-of-life care is needed, especially after an adverse event, such as a major change in clinical status or even after death of the patient.

Having established shared expectations built into the referral process would also allow for all parties to share their communications preferences at the outset, including the preferred format and method of contact for routine and more urgent communications. Communication must be bi-directional, and clinicians should always “close the loop.” Not only does the PC team need information and updates from SC, but SC should also receive updates from PC. All relevant parties should be updated of changes in health status, secondary findings, health care goals, or other relevant patient updates, including social determinants of health, as appropriate.

The critical elements in timely, productive communication must include:

- Consistent methods for bilateral communication documented in the CCA;
- Clear system for alerting when urgent action is needed; and
- Trained support staff helping facilitate timely communication across settings.

A practical application to a real-life scenario is as follows.

Patient undergoing liver transplant dies – PCP/GI team not notified. “Currently a major concern is preexisting team members involved in the patient’s care being ‘left out of the loop’ once the patient comes under specialty care for the consuming illness.”

Timely, Productive Communication” approach

It is important to ensure that all the patient’s clinical teams are aware of any new diagnosis or major changes in the patient’s health status. There are times when a phone call or other direct contact is the best way to ensure the parties are kept up to date on the situation with a mutual patient (please note that reimbursement for these communications must be explored and considered).

Principle 4: Effective Data Sharing

As with communication, data sharing needs to be bi-directional or multidirectional, based on the number of different clinicians/care teams involved in a patient’s care. Essential data should be readily accessible and not buried in unnecessarily lengthy progress notes. Information should also be organized in a format that allows relevant information to be easy to find and referred to as needed. The inbox for clinicians can be overwhelming. Knowing which items are most urgent and/or require action would be very helpful. Therefore, critical elements must include:

- Data sharing protocols should be established in the CCA, including ensuring that notifications are prioritized based on level of urgency. Utilization of an alert system could identify items as “FYI,” “Action Needed,” “Urgent,” “Notice of Major/Critical Event,” and so on to help prioritize items needing immediate attention or action.

A practical application to real-life scenarios is as follows.

Patient with T2D, Chronic Kidney Disease, Osteoporosis – multiple clinicians involved (GIM, Nephrology, Rheumatology, Cardiology, etc.) – no one knows what the other is doing (what tests have been done, any changes in diagnoses or treatments).

“Effective Data Sharing” approach

Many patients have more than one SC team involved in their care. SC should send a copy of their note from a follow-up visit to the PC and other relevant SC clinicians, and the PC clinician should also send copy of any relevant follow-up to the SC teams.

ACP recognizes that implementing new procedures or systems requires an upfront investment in clinician and staff time. As illustrated in our [Patients Before Paperwork Initiative](#), one of the College’s top, enduring advocacy priorities remains reducing administrative burden. Therefore, we emphasize that minimizing burden on clinical care teams should be of utmost priority when implementing the guiding principles and recommendations set forth in the paper “Beyond the Referral: [Principles of Effective, Ongoing Primary and Specialty Care Collaboration](#),” and corresponding [playbook](#). While we believe that many of these policies can be implemented with minimal disruption to patient care and clinical workflows, and expense to the practice, we also recognize that new policies and processes may need to be implemented on a gradual or prioritized basis to help minimize burden and ensure a smooth transition.

Principle 5: Reforming Physician Payment

Complementary in the effort to improve patient care among individuals managing MCC is the transition away from basing physician payment upon discrete, episodic episodes of care (i.e., traditional fee-for-

service payment). However, policymakers must consider that such payment models need and must receive investments to provide the needed high-quality, preventive, health promotion, coordinated, and whole-person and family-centered chronic care management, which affects sectors outside health care, including education, social services, and the justice system.

When managing patients with MCC, population-based, prospective payment provides greater opportunity for whole-person, patient-centered equitable care access and care delivery. In ACP's [paper](#) "Reforming Physician Payments to Achieve Greater Equity and Value in Health Care: A Position Paper of the American College of Physicians", the College recommends the below principles relevant to equitably managing patients with MCC.

- Medicare and other payers should progressively adopt population-based, prospective payment models for primary and comprehensive care that is structured and sufficient to ensure access to needed care and address the needs of individuals who are experiencing health care disparities and inequities.
- Delivery and payment systems must fully support physicians, other clinicians, and health care facilities in offering all patients the ability to receive care when and where they need it in the most appropriate manner possible, whether that be via in-person visits, telehealth, audio-only, or other means, particularly for those who are experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health (SDOH).
- Adequate funding must be made available to support the development of effective health information technology systems and communication mechanisms, including adequate broadband availability, to ensure that delivery and payment reforms are able to address the needs of all patient populations, including those that are experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by SDOH.

The College is confident that applying these principles, expectations, and critical elements will result in streamlined referrals, more effective and efficient care coordination, reduced overall burden on physician practices, equitable care access and delivery, and be well worth the initial investment.

Conclusion

ACP greatly appreciates this opportunity to share our views and provide requested information on person-centered care planning for MCC. The College continues to welcome partnership with AHRQ to revise regulatory policies and inform future rulemaking or legislation. If you would like to further discuss any of the information included in the letter, or have additional questions, please contact Brian Outland, Pd.D., Director, Regulatory Affairs, at 202-262-4544 or boutland@acponline.org.

Sincerely,



William Fox, MD, FACP
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