



AGENCY FOR HEALTHCARE RESEARCH AND QUALITY



Transforming Care for People Living with Multiple Chronic Conditions

Arlene Bierman, M.D., M.S.
Director, Center for Evidence and Practice Improvement
Agency for Healthcare Research and Quality

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Why MCC?

- Common, Costly
- Health equity issue
- Health system ill-designed to meet the needs of those at risk and/or living with MCC
- High burden on people living with MCC, their families and caregivers
- High burden on clinicians
- MCC syndemic meets Covid-19 pandemic

Why Now?

- Window of Opportunity
 - Ongoing crises
 - 88% of people hospitalized for covid have MCC
 - Racial and ethnic minorities, low income people disproportionately impacted by covid
 - Demography/ epidemiology
 - Payment incentives and penalties (readmissions)
 - Broader recognition of social determinants of health
 - New methods and capacities increase likelihood of success
 - New IT tools
 - New scientific methods
 - Great potential for more effective use of health care dollars while improving quality of life and population health

AHRQ FY 21 Presidential Budget



\$3.0 million is directed to new investigator-initiated grants focused on multiple chronic conditions (MCC).

MCC, Multi-morbidity or Burden of Illness?

- Multi-morbidity, a term often used synonymously with MCC, includes those with more than one chronic physical condition, more than one mental health diagnosis, or both
- Others use the term multi-morbidity to include additional factors that contribute to the burden of illness
 - ▶ disease severity
 - ▶ functional impairments and disabilities
 - ▶ syndromes such as frailty
 - ▶ social factors such as homelessness

AHRQ's Vision for People Living with MCC



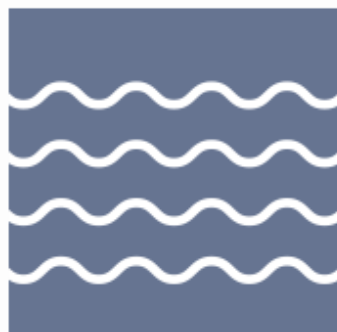
A sustainable healthcare system that delivers high-value coordinated, **integrated patient-centered care based in primary care** optimizing individual and population health by **preventing and effectively managing** multiple chronic conditions (MCC).

Addressing MCC Across the Continuum of Risk

- Prevention interventions targeted at reducing the prevalence of common chronic disease risk factors with a particular focus on interventions to reduce the likelihood those “**at risk**” will go on to develop MCC
- Targeted interventions to improve health and reduce the risk of adverse events and complications among those with multiple chronic conditions (e.g., diabetes, depression, and osteoarthritis) who are at “**rising risk**” for developing high needs and/or complex management issues
- Targeted interventions for those who have complex management issues and who are at “**high risk**” for avoidable adverse events, and require a focus on preventing decline, maximizing functioning, and improving quality of life



PERSON & FAMILY
CENTERED



CONTINUOUS



COMPREHENSIVE
& EQUITABLE



TEAM BASED &
COLLABORATIVE

Shared Principles of Primary Care



COORDINATED
& INTEGRATED



ACCESSIBLE

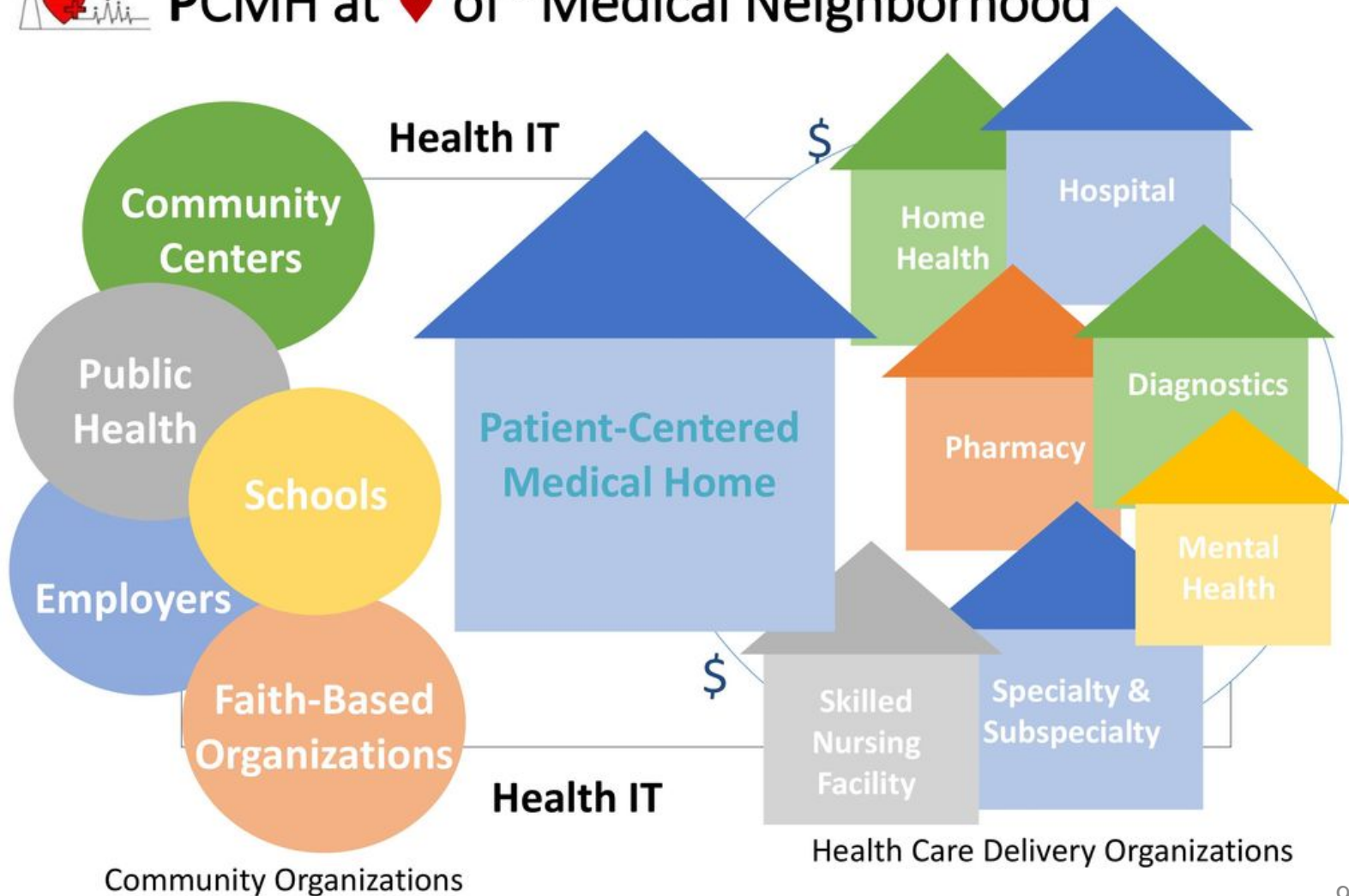


HIGH VALUE

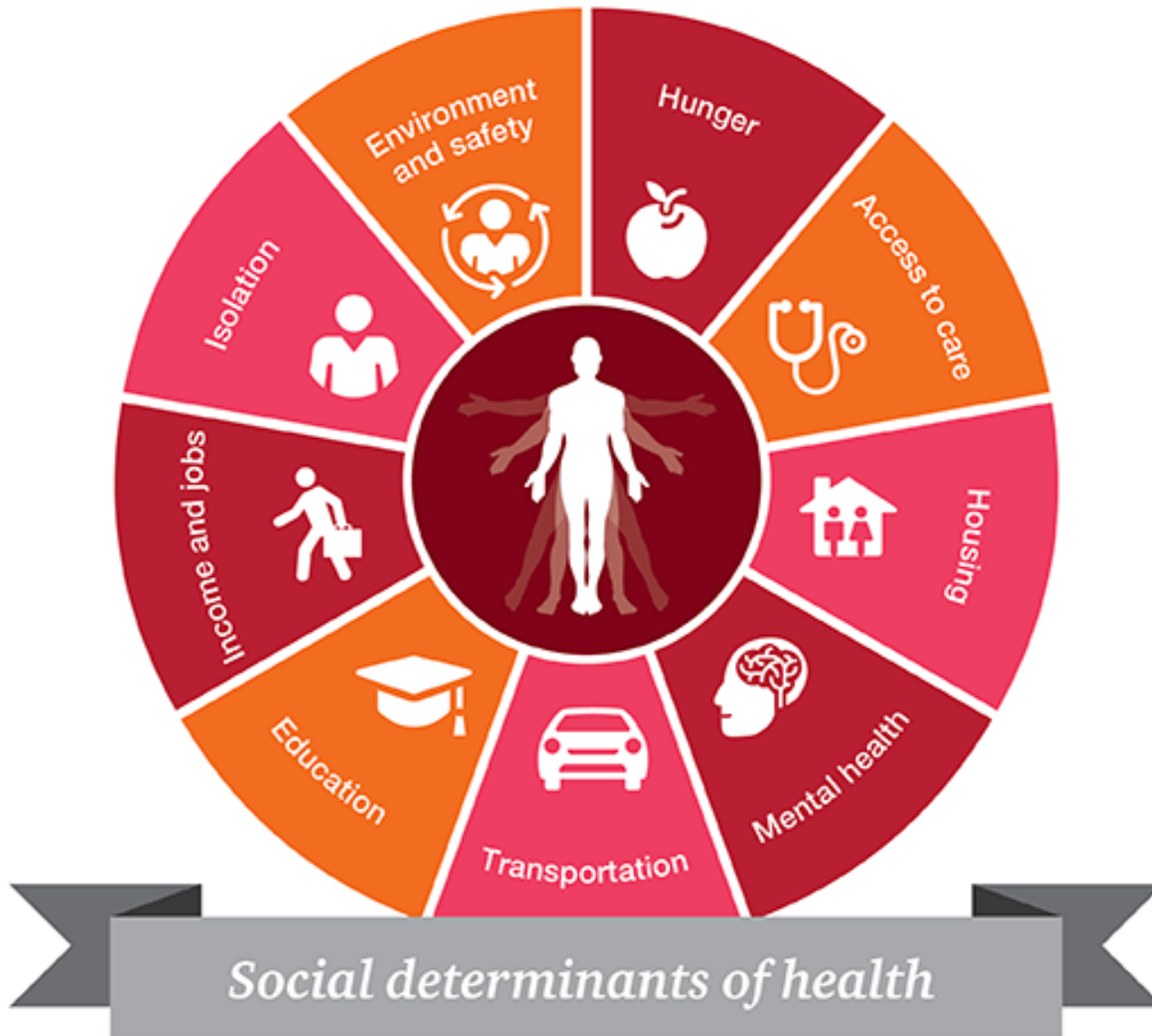
Medical Neighborhood



PCMH at ♥ of “Medical Neighborhood”



Health Community



Research: The Science of Care




- What works AND how do we make it work?
- Move from a system that treats diseases and focuses on illness to one that treats the people living with disease in the context of their lives and focuses on wellness
- Partnership research and co-production of evidence
- Research
 - ▶ Learning While Implementing (Integrating Quality Improvement and Implementation Science)
 - ▶ Multilevel Interventions
 - ▶ Agile Implementation
 - ▶ Mixed Methods
 - ▶ Complexity Science

Research Challenges

- Transformative vs. Incremental
- Complexity
- Timeliness
- Sustainability
- Equity
- Context

Who is here today?

- Patient Advocates
- Clinicians
- Researchers
- Health System Leaders
- Community Organizations
- Professional Societies and Organizations
- Policymakers
- Foundations/Funders
- Federal Partners



It always seems
impossible
until it's done

Nelson Mandela