ACCOUNTABLE CARE
LEARNING COLLABORATIVE
AT WESTERN GOVERNORS UNIVERSITY

A Call for Collaborative Action

Identifying Required Competencies for Success in Value-Based Care

CARE COORDINATION

ACLC Whitepaper Series

Governance & Culture
Financial Readiness
Health IT
Patient Risk Assessment
Care Coordination
Quality
Patient Centeredness

INTRODUCTION

The country is at an inflection point in how it pays for and delivers health care services. While much of the recent policy focus has been on payment reform, insufficient attention has been given to delivery reform. Public and commercial payers alike are increasingly adopting value-based payment agreements whereby providers are either financially rewarded or at financial risk, depending on whether they meet predetermined quality and spending outcomes. These payment models tell providers the quality or spending outcomes for which they are accountable, but they do not explain what the provider needs to do, or do differently, in order to achieve these goals.

In an industry-wide effort to assist providers with care delivery changes the Accountable Care Learning Collaborative (ACLC) has identified a core group of essential competencies that providers will need to develop in order to succeed in value-based care. The ACLC is introducing these competencies, in conjunction with a framework, as a starting place. We invite payers, providers, and the larger value-based care community to participate with us in evaluating and refining these competencies to help improve all providers' proficiencies under value-based agreements.

The care coordination whitepaper, part of the inaugural ACLC whitepaper series, highlights care coordination-specific competencies identified by the ACLC Care Coordination Workgroup and provides an explanation of the domain, value, methodology, and findings.

Additional whitepapers, the full list of competencies, and instructions for public comment can be found at **AccountableCareLC.org**.

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WHY CARE COORDINATION IS ESSENTIAL

A Duke study estimated a primary care physician would need to spend 21.7 hours per workday to provide all recommended acute, chronic, and preventive care for a panel of 2,500 patients. The authors concluded that a smaller patient panel is an unsustainable solution as there are not enough primary care physicians to meet the demand. An alternative approach, the Organized Team Model, allows physicians to provide care for a larger panel size while maintaining a high level of quality care.[1] Handoffs, or transitions between internal team members or external partners, becomes the focus under such models.

Because payments are now shifting from volume to value, providers are more incented to focus on care delivery improvement, by efficiently coordinating patient care across the spectrum of health care providers and services. Care coordination has become a central component in care redesign particularly because of the prevalence of chronic disease. Coordinated care is less episodic and more continuous, which in turn enables a greater focus on multi-disciplinary and whole-person care. The complexity in providing robust care coordination programs on a large scale for a population cannot be overestimated, particularly when chronic diseases now account for three-fourths of health care spending.[2] Under risk-based arrangements it is imperative that effective care coordination programs are either established or maintained.

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METHODOLOGY

Literature Review

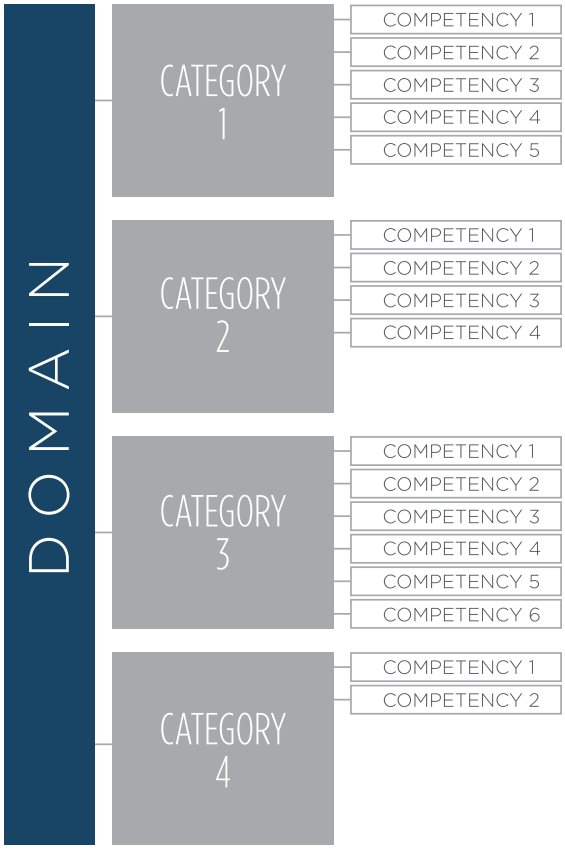
The ACLC research staff utilized a structured approach to identify a list of competencies for each domain. The first step involved the review of various frameworks and literature geared toward preparing providers to bear financial risk. Through a qualitative analysis, the staff identified common themes of competencies and mapped out language differences and commonalities to reveal general industry agreement on seven competency 'domains.' Preliminary sub-domains or 'categories' were created to organize competencies into more manageable groups for review and refinement (e.g. 'Ease of Access' category under the 'Patient Centeredness' domain). A second literature review was then conducted based on the seven domains, scanning for specific guidance on categorization schemes and distinct competencies within each domain. Initial competency domains and categories were then offered to ACLC members for their review.

ACLC Domains

- Governance and Culture
- Financial Readiness
- Health IT
- Patient Risk Assessment
- Care Coordination
- Quality
- Patient Centeredness

Workgroup Review and Refinement

Commensurate with the number of domains, seven workgroups were assembled to provide multi-stakeholder review of the preliminary research and give further direction. Each workgroup was chaired by an individual nationally known for expertise in the domain and comprised of ACLC members who indicated specific interest or expertise in a domain. Workgroup members were then given documents that contained the full literature review and analysis along with access to the original documents for reference. Virtual and in-person workgroup meetings were held to review sources, create and refine domain titles and categories and to develop descriptive narrative language for each. Additional vetting and refinement of the domains, categories, and specific competencies was accomplished via email and conference calls. Specific attention was given to recognize and resolve overlap between and among competencies. Workgroup chairs held additional meetings to review proposed competencies, coordinate content, and identify overlap.



WORKGROUP CONCLUSIONS

Domain

The workgroup evaluated several care coordination models including those prepared by the National Quality Forum, Robert Wood Johnson Foundation, the National Academy of Medicine, the Family Caregiver Alliance, the Agency for Healthcare Research and Quality, the University of California San Francisco, the Commission for Case Manager Certification, and the Case Management Society of America.

The workgroup chose to draw largely from definitions by the National Quality Forum and Agency for Healthcare Research and Quality. In addition to key concepts embedded in these definitions, the workgroup suggested emphasis be placed on access, accountability, evidence, family caregivers, teams, and continuity. The workgroup proposes the following definition:

"Care coordination is an evidence-based approach which ensures that individuals', family caregivers' and targeted populations' needs and preferences for health information and services are met over time. Optimally, care coordination facilitates access to and integration of appropriate health and community-based services, aligned with varying levels of health and social risk, in a timely, person centered manner that fosters continuity of care. Accountability for care coordination is shared among all team members with continuous assessment of performance essential to assure high value."

Terminology

The workgroup recognizes the importance of ensuring a common understanding of key terms in the domain definition, as well as the categories and competencies derived from this definition. The following are proposed definitions for selected key terms:

1. **Individual –** The recipient of care coordination (patient, consumer, client).
2. **Family Caregiver –** Relative, friend, neighbor, or paid assistant who assumes primary responsibility for the care of the individual.
3. **Targeted Population –** Group of individuals with common health issues (e.g., a specific disease such as diabetes or vulnerability such as behavioral health conditions, multiple chronic conditions, homelessness, etc.)
4. **Teams –** Individuals, family caregivers, health care professionals, and support staff (e.g., community health workers) who collectively share accountability for high value care coordination.

Categories

The workgroup recognizes that a complete list of competencies is difficult to evaluate. In order to make evaluation of available competencies most efficient, the workgroup created a multi-part categorization scheme. **These categories present a framework by which providers may quickly identify groups of competencies for which they seek additional understanding.** Below are the five categories with accompanying definitions and the corresponding number of competencies in parenthesis:

1. **Access (4):** Providing patients with access to appropriate care, either through increasing organizational resources or providing access to other care and community resources.
2. **Care Management (14):** Effectively managing medical and psychosocial conditions such that the patient's health and emotional status will be improved, or that the patient's emotional status will be improved if the health status cannot be improved.
3. **Care Team (4):** Inter-disciplinary and non-health professionals working together with the patient and family/caregivers to provide effective and coordinated care.
4. **Care Transitions (5):** Movement of patient and relevant information from one care setting to another.
5. **Wellness & Prevention (4):** Identifying and promoting activities that promote health and prevent disease.

It is important to note that although these are the categories that made sense to this particular group of commissioned reviewers, we expect providers to redefine and/or add to these categories such that they are more applicable to their unique circumstances.

Competencies

The care coordination workgroup has identified 31 competencies. The list of competencies is by no means exhaustive. We welcome further investigation and additions by other groups and individuals and we hope this current list will provide a good foundation for that work. We refer the reader to the full competency list in the table below, but include one example from the workgroup discussion here for illustrative purposes.

The University of Pennsylvania's Transitional Care Model (TCM) utilizes advance practice nurses to manage the health problems of the elderly, particularly those with multiple health problems, as they transition from hospital to home. The TCM program has helped reduce Pennsylvania's in-hospital mortality rates and hospital readmission rates for a number of conditions. In-hospital mortality rates decreased for pneumonia from 10% to 7%, heart attack from 10.2% to 8.1%, and stroke from 5.1% to 3.7%. Readmissions decreased for congestive heart failure from 27.2% to 23.5%, and for pneumonia from 27.5% to 22.2%.[3]

CATEGORY	COMPETENCY LABEL	COMPETENCY
ACCESS	CC.1.1	Offer primary care and specialist extended hours
	CC.1.2	Offer access to and integrate with behavioral health services
	CC.1.3	Facilitate access to community resources and social services
	CC.1.4	Offer access to patient self-management resources and tools such as nurse call lines, disease-specific patient support services, etc.

Competencies (cont'd)

CATEGORY	COMPETENCY LABEL	COMPETENCY
CARE MANAGEMENT	CC.2.1	Assure the care plan is accessible and can be modified by all stakeholders and contains the patient's most updated goals, preferences (including MOLST and POLST), results, and clinically relevant information
	CC.2.2	Conduct ongoing patient outreach programs to improve the health of the targeted population
	CC.2.3	Develop, document, and follow effective communication protocols within care teams and partnering organizations
	CC.2.4	Engage in patient centered care planning and shared decision-making
	CC.2.5	Establish care protocols and ensure that staff have adequate training
	CC.2.6	Identify gaps in patient understanding of conditions and treatments, and provide appropriate education and health coaching
	CC.2.7	Design care management systems which are both medical and social in approach
	CC.2.8	Integrate legal factors into operations including patient legal capacity for decision making, guardianship, mental health, consent, etc.
	CC.2.9	Implement medication systems and programs including medication reconciliation, medication therapy management, real-time alerts for duplicate medications and contraindications, reports for prescriptions not filled, etc.
	CC.2.10	Use patient assessment tools that are tailored to the abilities of the patient
	CC.2.11	Provide timely notifications to PCP / Care Team of key patient activities such as emergency department visits, hospital admission and discharge, failure to fill prescriptions, diagnostic tests not completed, overdue results, skipped referral appointments, etc.
	CC.2.12	Use peer-reviewed research and tools to guide interventions and activities
	CC.2.13	Implement chronic disease, self-management processes for high-volume, high-cost patients with chronic illness
	CC.2.14	Utilize technology to maximize patient outcomes and provider efficiency
CARE TEAM	CC.3.1	Include multi-disciplinary members, including patient, family caregivers, community members who are willing to focus on meeting the goals
	CC.3.2	Develop care teams with well-defined roles and responsibilities for planning, coordinating, and assuming accountability for continuity of patient care across the continuum
	CC.3.3	Establish the patient's/caregiver's goals of care and priorities, and ensure all care team members are advocates for these goals and priorities
	CC.3.4	Implement methods for the care team to receive reliable and timely feedback on the functioning of the team and achievement of the team's goals

Competencies (cont'd)

CATEGORY	COMPETENCY LABEL	COMPETENCY
CARE TRANSITIONS	CC.4.1	Designate a primary coordinator of care to assure continuity throughout the episode of care
	CC.4.2	Develop care transition protocols to reduce unnecessary emergency room visits and hospital admissions
	CC.4.3	In-hospital assessment and collaboration to reduce adverse events and prevent patient's functional decline, and preparation of a streamlined, evidence-based plan of care
	CC.4.4	Identify a comprehensive, holistic focus on each patient's goals and needs including the reason for hospitalization as well as other complication or coexisting problems
	CC.4.5	Collaborate and communicate among the stakeholders across the episode of care
WELLNESS & PREVENTION	CC.5.1	Offer ongoing wellness classes and lifestyle change support groups
	CC.5.2	Engage in relevant public health interventions to improve population health
	CC.5.3	Gather data from local, state, and federal public health registries
	CC.5.4	Conduct community outreach programs for high-need patients such as home visits, virtual visits, etc.

NEXT STEPS

The care coordination information presented in this paper is a starting point and marks the beginning of a public comment period. The ACLC will release a series of subsequent revisions as comments and the perspective of future members are reviewed and incorporated. It is anticipated that the work will substantially evolve over time as more information, evidence, and perspective is acquired.

There is more to do than just refine the domains, associated competencies, categories and definitions inventoried here. Going forward the ACLC will begin identifying stages of competency attainment, recognizing that not all competencies can or should be advanced simultaneously. ACLC members will also begin stratifying competencies by the type of organization and risk arrangement. For example, an integrated health care system will have a different starting point and possibly end goals than a single practice specialty group. The ACLC will also create a resource center where evidence including case studies, vendor information, and other relevant materials will be available and disseminated, all with the goal of advancing and accelerating the successful adoption of value-based care arrangements.

To provide comments to the work of this workgroup or others and to learn more about how you can help contribute to this shared body of knowledge, please visit AccountableCareLC.org.

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About the Accountable Care Learning Collaborative

The ACLC accelerates the transition to accountable care by identifying what providers need to succeed in value-based payment models. Through collaborative forums, members contribute their understanding and experience in the real world of accountable care implementation. The ACLC is managed by Leavitt Partners, LLC.

About Western Governors University

The ACLC is at Western Governors University (WGU), a leading innovator in health care education. WGU offers over 50 online bachelor's and master's degree programs that are accredited, flexible and competency based, serving the needs of working adults. Degree programs include nursing, health informatics, business administration, and integrated health care management. WGU prepares future leaders for the world of accountable care.

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