# ACCOUNTABLE CARE
## LEARNING COLLABORATIVE
### AT WESTERN GOVERNORS UNIVERSITY

# *A Call for Collaborative Action*

## Identifying Required Competencies for Success in Value-Based Care

## ▸ HEALTH IT

# ▶ 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 health IT whitepaper, part of the inaugural ACLC whitepaper series, highlights health IT-specific competencies identified by the ACLC Health IT 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 HEALTH IT IS ESSENTIAL

When treating patients, 82% of hospital providers rarely or never use health information received electronically from other providers. Despite the progress made through a decade of focus on health information interoperability, the information received from the other providers is difficult to integrate into the hospital electronic health record (EHR); therefore, it is not available in the hospital EHR as part of the workflow.[1]

For innumerable reasons, it is no surprise that interoperability of health information has been, and remains, a national priority. In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress declared achieving the widespread exchange of health information through interoperable certified electronic health record (EHR) technology by December 31, 2018 a national objective.[1]

Health IT is the infrastructure that underpins essentially all of the competencies that provider groups must master to succeed in a financial risk-based environment including better understanding the quality and costs associated with care.

*"Health IT is the infrastructure that underpins essentially all of the competencies that provider groups must master to succeed in a financial risk-based environment"*

# ▶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.

## *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.

### *ACLC Domains*

▸ Governance and Culture
▸ Financial Readiness
▸ Health IT
▸ Patient Risk Assessment
▸ Care Coordination
▸ Quality
▸ Patient Centeredness
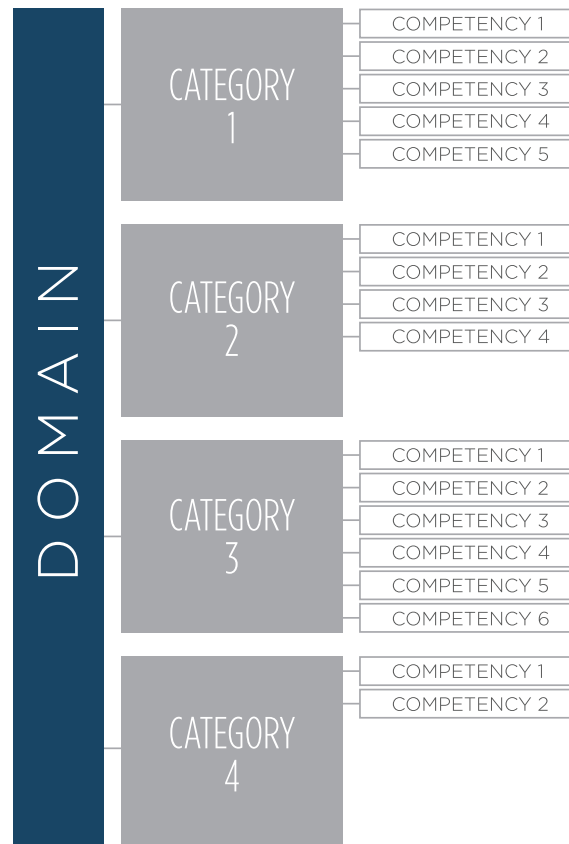
# ▶ WORKGROUP CONCLUSIONS

## *Domain*

Electronic health records and interoperability, or sending and receiving data, are only a part of the health IT landscape. First and foremost, health IT enables improved and shared access to the clinical data necessary to manage patients comprehensively, track outcomes and costs, evaluate process changes, plan resource use, and better engage and self-activate patients. It also substantially enhances the ability to analyze patient and population health data through registries. Without EHRs, data warehouses, and analytics, taking on financial risk arrangements is likely ill-advised.

Second, the health IT infrastructure must be able to share and incorporate data from external sources as the provider moves into accepting more financial risk. Integrating behavioral health, for example, is a well-established approach to decreasing overall costs, but behavior health providers are frequently not in or on the same system. Additionally, primary care providers that do not admit their patients to hospitals and have different EHR systems need information on the course of care, planned follow-up, and medications as the patient is discharged. There are multiple ways that all types of information – clinical, administrative, or social – can be shared. Any provider moving into downside risk should carefully assess options and opportunities for data and information exchange among multiple other entities.

Third, health IT is not just about the data and information. It's also about e-communications (telehealth) that allow visual and audio information as well as interventions to pass, either in real-time or asynchronous, between clinicians, or between clinicians and patients, virtually when both are in different locations. Included are audio/visual interactions, remote monitoring, robotics, and mHealth modalities that are burgeoning throughout the delivery system to increase access to care, educate and support clinicians, coordinate care, interact with patients, and even conduct care robotically. Most providers use telemedicine (telehealth modalities that provide actual care) as a starting point to increase more timely access to care and to maintain a close connection with patients who may seek care elsewhere if it is not available when needed. Remote monitoring devices have become important tools for coordinating the care of high-risk patients. Reminder texts to patients have has also become mainstream in some larger organizations. While reimbursement has long been a barrier to these services, these new value-based payment options increasingly include the use of telehealth.

Recognizing that health IT enables or enhances a wide range of provider competencies particularly relevant under risk-bearing arrangements the workgroup provided the following definition:

*Health IT is "The electronic information system and network along with relevant strategy and processes that support all aspects of value-based payment and care delivery."*

## *Terminology*

The workgroup recognizes the importance of 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. **Telehealth** – "The Health Resources and Services Administration (HRSA) defines telehealth as the use of electronic communication and information technologies to provide or support long-distance clinical health care, patient and professional health-related education, public health, and health administration."
2. **Telemedicine** – The subset of telehealth that is focused on care provided by a licensed clinician.
3. **m-Health** – An abbreviation for mobile health, meaning the use of mobile devices for health care or improvement of health.
4. **eHealth** – Another term for telehealth
5. **Integrating/Integration** – In health IT, the term means the merging of disparate data sets with fidelity such that a unified set can be used for data analytics.

## *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 six categories with accompanying definitions and the corresponding number of competencies in parenthesis:

1. **HIT Infrastructure (7):** Products, platforms, processes, and investments that support the organization's strategy for accessing and using health data and information that will support the organization's short and long term priorities and goals.
2. **Data Acquisition (6):** Identifying, accessing, ingesting, integrating, and managing data from multiple sources needed to support the organization's plans and initiatives.
3. **Data Analytics (2):** Use of available data for descriptive, predictive, and prescriptive analyses and report development.
4. **Information Sharing (3):** Ability to access and provide patient specific data among appropriate clinicians and share reports and information across all involved stakeholders.
5. **Communication (3):** Use of technologies for interactions dependent on finely nuanced, textual, or audio-visual information not captured by structured data including interactive audio-visual technology, asynchronous communications, remote monitoring, robotics, and eHealth.
6. **Behavior Change (1):** Presentation of data and information so that it can be embedded in provider workflows and provided to patients in ways that will enhance engagement in their own health and care.

## *Competencies*

The health IT workgroup has identified 22 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 below table, but include one example from the workgroup discussion here for illustrative purposes.

One of the lessons learned in this value-based payment environment is the importance of knowing where attributed patients are receiving their care for planning purposes. An ACO will naturally want to keep its attributed patients within its own network of providers. However, given the open nature of ACOs, patients may be receiving care in multiple other settings, at cost to the ACO. Analyses of payer data (Massachusetts has an All Payer Data Base that will provide these data to ACOs) reveals where this outside care is occurring and its associated costs. Steps can then be taken to assure that patients have access to the care they need within the ACO structure.

| CATEGORY | COMPETENCY LABEL | COMPETENCY |
|---|---|---|
| HIT INFRASTRUCTURE | HIT.1.1 | Create a health IT strategy |
| | HIT.1.2 | Analyze and mitigate eHPI security risks |
| | HIT.1.3 | Assess the health IT ecosystem across the organization |
| | HIT.1.4 | Develop a stable platform for information systems |
| | HIT.1.5 | Coordinate appropriate staffing to maintain infrastructure |
| | HIT.1.6 | Assess IT strategy and infrastructure |
| | HIT.1.7 | Share data and information containing ePHI securely |
| DATA ACQUISITION | HIT.2.1 | Identify data needed for priority programs and processes |
| | HIT.2.2 | Gather data and information from multiple sources |
| | HIT.2.3 | Capture important information as structured data |
| | HIT.2.4 | Aggregate data and information |
| | HIT.2.5 | Ensure data acquisition process remains uninterrupted |
| | HIT.2.6 | Maintain integrity of data and information |
| DATA ANALYTICS | HIT.3.1 | Analyze data to create useful information |
| | HIT.3.2 | Create reports and insights for all stakeholders |
| INFORMATION SHARING | HIT.4.1 | Share patient specific data among clinicians |
| | HIT.4.2 | Share reports, whether data and/or information at either a population or patient level, with internal and external stakeholders |
| | HIT.4.3 | Provide timely notifications, including when a patient is admitted or discharged from acute care, presents at the emergency department, does not fill a prescription, and does or does not keep a referral |
| COMMUNICATION | HIT.5.1 | Communicate effectively with patient and family/caregivers |
| | HIT.5.2 | Communicate effectively with internal care team |
| | HIT.5.3 | Communicate effectively with external partners and stakeholders |
| BEHAVIOR CHANGE | HIT.6.1 | Create decision support rules that assist with providing effective care |

# ▶ NEXT STEPS

The health IT 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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# Workgroup Members

**Erik Pupo,** *Accenture*

**Mary Coppage,** *American Medical Association*

**Luke Harris,** *Children's Mercy Integrated Care Solutions*

**Sharon West,** *College of American Pathologists*

**Vikas Garg,** *Conifer Health Solutions*

**Dan Soule,** *Health Catalyst*

**Jason Lerner,** *Johnson & Johnson*

**Terri Kennedy,** *Kansas Association for the Medically Underserved*

**Taylor Davis,** *KLAS Enterprises*

**Keith Blankenship,** *Lumeris*

**John Lees, PhD,** *Managed Health Care Associates, Inc.*

**Laura Kanov,** *Medecision*

**Jessica Kratz,** *Merck & Co. Inc.*

**Dorothy Fisher, MD,** *Sentara Quality Care Network*

**Sara Taylor,** *Seton Health Alliance*

**Anthony Brockman,** *St. Vincent's Health Partners*

**Jeff Goldman,** *Valence Health*

## 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.

## Acknowledgements

## Bibliography

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