ACCOUNTABLE CARE
LEARNING COLLABORATIVE
AT WESTERN GOVERNORS UNIVERSITY

A Call for Collaborative Action

Identifying Required Competencies for Success in Value-Based Care

PATIENT CENTEREDNESS

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 patient centerdness whitepaper, part of the inaugural ACLC whitepaper series, highlights patient centerdness-specific competencies identified by the ACLC Patient Centerdness 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 PATIENT CENTEREDNESS IS ESSENTIAL

A 2016 Commonwealth Fund study found that patients who didn't feel competent to manage their own conditions or guide themselves through the health care system were "more likely to develop a chronic disease over a three-year period than 'activated' patients with good self-management skills."[1] Additionally, recent landmark legislation, including the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act, has established clear goals by including specific measures for making the patient more central to new care models.[2]

Current value-based care models break with previous initiative reforms by including population health improvement as the ultimate financial and quality standard. Additionally, shifting from episodic care to a more comprehensive delivery approach requires a level of patient involvement that is also markedly different than traditional care delivery. A 2013 Institute of Medicine workshop concluded: "Prepared, engaged patients are a fundamental precursor to high-quality care, lower costs and better health."[3] The term that best captures this notion is "patient centeredness" (please see Workgroup Conclusions below for further discussion of this term and related terminology). Beyond the important moral arguments for patient involvement, there are three elements in particular that underscore "patient centeredness" as an essential organizational strategy. First, the patient has to actually be present in order to benefit from newly-incentivized care efforts. Second, direct patient input is needed to give the full picture and make a proper diagnosis. In many markets, the patient is still the only true connection point in their own health care ecosystem where multiple providers are not able to share information for whatever reason. Third, fully involving the patient allows for genuine shared decision-making and greater patient adherence and self-management.

"Prepared, engaged patients are a fundamental precursor to high-quality care, lower costs and better health."

METHODOLOGY

Literature Review

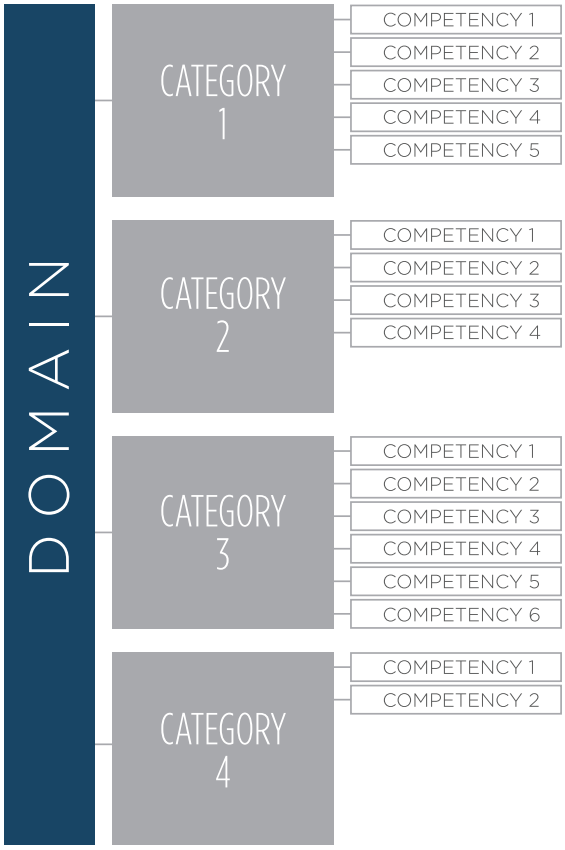
The ACLC research staff utilized a structured approach to identify a list of competencies for each domain. The first step involved the review of various frameworks and literature geared toward preparing providers to bear financial risk. Through a qualitative analysis, the staff identified common themes 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 initially faced three challenges to defining "patient centeredness" for risk-bearing provider entities. First, the concept grew out of the traditional clinical encounter and therefore has had limited applicability to providers who are responsible for a patient's health even outside the clinical setting. Second, despite the wide spread use of the term there is no agreed-upon definition particularly as it relates to measurement.[4,5] Third, the word "patient" can be controversial as "patient" could be seen to reinforce a relationship based upon traditional roles. In response to the first challenge, value-based care models will necessarily expand the application of the term as risk-bearing provider entities work to define what patient centeredness means outside the traditional clinical setting. To address the issue of definition consensus, the workgroup decided to avoid proposing a new, "universal" definition. Instead, the workgroup proposes a definition that is broad enough to align with the work of other important groups in this field (Picker, National Partnership for Women and Families, etc.), but is refined for the accountable care context. Regarding the third challenge, the workgroup concluded that today's language doesn't currently have a better term than "patient" to characterize an individual for whom an organization has clinical responsibility. As the scope of responsibility for the patient broadens, a more holistic definition will evolve. Therefore, the definition proposed by the workgroup is as follows:

"A patient-centered organization helps individuals stay healthy and return to health when they are sick or injured while incorporating the patient perspective into governance, care system design, and individual interactions at all times in all settings."

Terminology

In addition to addressing the important topic of a definition for the domain itself, the workgroup wanted to ensure that some of the terminology regarding the definition and scope of is clear for those intending to put these concepts into practice. Below are a set of terms that, while not highly controversial in their meanings, could benefit the reader. All four terms had authoritative definitions and sources that the workgroup wanted to point toward for the sake of clarity and industry harmonization.

1. **Shared Decision Making** - "[A] collaborative process that allows patients and their providers to make health care decisions together. It takes into account the best clinical evidence available, as well as the patient's values and preferences."[6]
2. **Cultural Competency** - "[The] ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences."[7]
3. **Patient and Family Advisory Council** - "[A] formal group that meets regularly for active collaboration between clinicians, hospital staff, and patients and family members on policy and program decisions."[8]
4. **Caregiver** - [Typically] family members, friends, and neighbors… [who provide] unpaid assistance and support to family members or acquaintances who have physical, psychological, or developmental needs."[9]

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 four categories with accompanying definitions and the corresponding number of competencies in parenthesis:

1. **Whole-Person Orientation (13):** Care approach takes into account the variety of influences on a patient's health and their self-defined quality of life.
2. **Patient Involvement (16):** Facilitates patient input and involvement of a patient's support network including shared decision-making.
3. **Ease of Use (20):** Care delivery is designed around the patient to ensure usability and accessibility.
4. **Governance and Culture (9):** Concern for patient input is demonstrated by patient inclusion in governing bodies and organizational policies.

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 patient centeredness workgroup has identified 58 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.

Currently, in most cases, there exists little incentive for a provider to be concerned with the specific quality results or reimbursement rate of a provider to which a patient is being referred. Workgroup discussions (and a related discussion in the care coordination workgroup) determined that in order for the health system to be made truly accessible to the patient, it would be necessary that a risk-bearing provider entity "[provide] information on preferred providers, their results, and their rates." One could imagine a patient being referred to an excellent specialist, but due to financial restraints not actually getting important follow-up care from that physician. Alternatively, if the primary care provider and the patient can have a more open and comprehensive discussion about treatment options, quality, and finances, a reasonable and cost-effective alternative that is more appropriate given the specific circumstances of the patient and his or her condition may emerge.

Competencies

CATEGORY	COMPETENCY LABEL	COMPETENCY
EASE OF USE	PC.1.1	Capture and demonstrate respect for an individual patient's values, preferences, and expressed needs and concerns
	PC.1.2	Evaluate limitations to communication including language barriers, hearing, vision and mobility for risk assessment
	PC.1.3	Make printed versions of patient education materials available to clinics and patients
	PC.1.4	Provide patient-facing information in plain language, in patient's preferred language (including to those with cognitive or communication impairments), with links to explanatory sources
	PC.1.5	Give patients the ability to monitor appointment availability and to make reservations online or by phone
	PC.1.6	Help patients build a personal relationship with their providers by keeping their care team as consistent as possible
	PC.1.7	Provide each patient with 24/7 access to a member of their care team
	PC.1.8	Make in-home care available to patients with access, communication, or transportation issues
	PC.1.9	Ensure access to health care services via physical or virtual means based upon the needs and expectations of the patients
	PC.1.10	Facilitate physical access to health care facilities for all patients, including ensuring that there are adequate parking and transportation options
	PC.1.11	Ensure that patients can refill their medication 24/7, including through online and mobile ordering
	PC.1.12	Educate patients and the public on the aims and potential benefits of health reform efforts, including the ACO model and the patient-centered medical home
	PC.1.13	Provide robust background data on internal providers to facilitate informed decision making
	PC.1.14	Provide information on preferred providers, including their results and rates
	PC.1.15	Make quality and cost data available to providers at appropriate decision points, such as before service is performed
	PC.1.16	Provide patients with billing information that is accurate, up-to-date, and easy to understand
	PC.1.17	Provide patients access to their personal health record, including access to their cumulative out-of-pocket expenditures
	PC.1.18	Provide access to reliable and timely insurance information
	PC.1.19	Assist patients in obtaining and understanding their health insurance and get connected to community resources
	PC.1.20	Leverage consumer technology to improve patient experience

Competencies (cont'd)

CATEGORY	COMPETENCY LABEL	COMPETENCY
GOVERNANCE & CULTURE	PC.2.1	Measure patient satisfaction, incorporate patient feedback, and respond to grievances in a transparent manner
	PC.2.2	Ensure patient participation on governing boards, patient advisory committees, leadership committees, and oversight committees
	PC.2.3	Write a formal policy that affirms patients' rights and responsibilities, and protects patient privacy
	PC.2.4	Establish patient centered policies that take into account reimbursement mechanisms, benefit design, and purchaser policies
	PC.2.5	Ensure that external communications and marketing convey the importance of patient centeredness
	PC.2.6	Incorporate patient-related concerns into efforts relating to staff support redesign, quality improvement, and assessment of capital investments
	PC.2.7	Publish a description of ACO participants, cost and quality results, infrastructure investments, savings distributions, and patient experience survey results
	PC.2.8	Foster a culture of teamwork and mutual dependence within your organization
	PC.2.9	Financially reward providers for giving patient centered care
PATIENT INVOLVEMENT	PC.3.1	Measure patient satisfaction, incorporate feedback, and respond to specific complaints or grievances in a transparent manner
	PC.3.2	Ensure patients and their designated caregivers are involved in decision making and self-management
	PC.3.3	Ensure that patients and designees have secure access to understandable and useable personal health information in a variety of formats (free text, documents, and structured data)
	PC.3.4	Allow patients to fill out patient information forms and relevant applications online, including on mobile devices
	PC.3.5	Allow patients to amend their clinical record or comment on their clinical record
	PC.3.6	Incorporate data from remote monitoring devices or programs
	PC.3.7	Make available a complete record of every medical encounter (audio recording or transcript)
	PC.3.8	Enable patients to select their preferred care team
	PC.3.9	Give patients and providers the opportunity to sign quality contracts, which include care plans and goals for the year, and to evaluate each other's performance
	PC.3.10	Make available shared decision supports with links to information on relevant topics such as advanced care planning, health proxies, and patient-directed health technologies

Competencies (cont'd)

CATEGORY	COMPETENCY LABEL	COMPETENCY
PATIENT INVOLVEMENT (cont'd)	PC.3.11	Educate patients on the wise use of health care services
	PC.3.12	Employ behavioral science techniques, such as motivational interviewing, to engage patients
	PC.3.13	Educate patients prior to and after clinical encounters, with particular emphasis on home education
	PC.3.14	Communicate to patients recalls, public health alerts, motivational messages, reminders, and other opportunities to engage in care
	PC.3.15	Communicate patient centered progress to the public through a variety of communications
	PC.3.16	Create volunteer opportunities for patients to help other patients
WHOLE PERSON ORIENTATION	PC.4.1	Organize services around integrated patient journeys as opposed to being organized around service lines or departments
	PC.4.2	Coordinate patient care across teams and systems
	PC.4.3	Maintain an active relationship with community-based organizations to ensure better coordination on behalf of the patient
	PC.4.4	Make use of connection opportunities when patients end up in acute care settings such as hospitals or skilled nursing facilities
	PC.4.5	Establish protocols to communicate results and summaries to patients in a designated timeframe
	PC.4.6	Support multiple levels of analysis that enable care management for specific sub-populations and individual patients
	PC.4.7	Monitor patient care plan milestones and goals
	PC.4.8	Use wellness visits to evaluate patients and to develop a care plan
	PC.4.9	Utilize patient and caregiver assessment tools to address gaps, capture functional status, behavioral health status, social service needs, and barriers to care
	PC.4.10	Use patient survey to assess and set in motion a personalized patient engagement strategy
	PC.4.11	Collaborate with patients to create culturally appropriate care plans
	PC.4.12	Proactively reach out to patients to prevent them from becoming high or rising-risk patients
	PC.4.13	Ensure the physical and emotional comfort of the patient

NEXT STEPS

The patient centeredness 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

Harvinder Sareen, PhD, *Accenture*
Carol Alter, MD, *AstraZeneca LP*
Doug Blowey, MD, *Children's Mercy Integrated Care Solutions*
Ellie Soeffing, *Conifer Health Solutions*
Barbara Phillips, MD, *Eastern Connecticut Health Network*
Valerie Overton, *Fairview Health Services*
Donna Cryer, *Global Liver Institute*
Carla Smith, *HIMSS*
Robert Dyer, PhD, *Jefferson Center for Mental Health*
Kay Sadik, *Johnson & Johnson*
Drew Kraisinger, *Medecision*
Edward Slaughter, *Merck & Co. Inc.*
Troy Tanner, *Managed Health Care Associates, Inc.*
Cheryl Modica, PhD, *National Association of Community Health Centers*
Lauren Murray, *National Partnership for Women and Families*
Kurt Stuessi, *Novartis Pharmaceuticals Corporation*
Michael Crutchfield, *Ohio Shared Information Systems*
Geoff Teed, *Paradigm Provider Partners*
Jerry Grannan, *Parkview Health*
Yahaira Almonte, *RGV ACO Health Providers*
Christina Freese-Decker, *Spectrum Health*
Kyle Lanning, *St. Vincent's Health Partners*
Jill Erickson, *Takeda Pharmaceuticals U.S.A.*
Julie Sommer, *TriZetto*

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, serv-ing 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

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