



# *A Call for Collaborative Action*

Identifying Required Competencies for Success in Value-Based Care

## ► QUALITY

### *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 quality whitepaper, part of the inaugural ACLC whitepaper series, highlights quality-specific competencies identified by the ACLC Quality 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](https://AccountableCareLC.org).

*“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.”*

## ▶ WHY QUALITY IS ESSENTIAL

According to a 2014 Commonwealth Fund report that rank ordered 11 comparable industrialized countries, the U.S. ranked last in overall health care quality, access, and efficiency.<sup>1</sup> In the same report, the U.S. ranked seventh in safe care.

The 2001 landmark Institute of Medicine publication, “Crossing the Quality Chasm”<sup>2</sup> implored the health care industry to reinvent health care in this country that was safe, effective, patient-centered, efficient, timely, and equitable. In the 15 subsequent years, the science of clinical practice improvement in health care has advanced significantly; yet the application of this science to the clinical practice setting continues to lag far behind collective expectations.<sup>3</sup> If health care providers cannot practice adequate hand hygiene,<sup>4</sup> screen for chronic depression,<sup>5</sup> or provide routine and consistent management of diabetes,<sup>6</sup> how will they manage complex processes like sepsis or provide team-based care in a population management framework?

Quality in health care delivery continues to cry for highly reliable care in all facets. This requires quality expertise as an organizational strategy that includes, leadership, data measurement and reporting, a culture and framework for continuous learning and improvement, and intelligently selected partnerships that promote best practices.

A 2014 Advisory Board report indicated that a vast majority of health care organizations planned to implement shared savings contracts by 2017, yet a minority of those participating in these contracts had demonstrated financial upside.<sup>7</sup> The report continued to argue that an “inadequate focus on quality” was one of the most glaring mistakes a health care organization could make in transitioning to value-based payments and financial success under that model.

Fifteen years later, we continue to straddle the Quality Chasm. However, risk-based payment models will force providers to improve quality outcomes in order to meet their spending targets or benchmarks. A comprehensive and robust quality strategy must be a component of every health care organization that seeks to remain viable and/or succeed in risk-based contracting and population health.<sup>8</sup>



*“An ‘inadequate focus on quality’ was one of the most glaring mistakes a health care organization could make in transitioning to value-based payments”*

## ► METHODOLOGY

### *Literature Review*

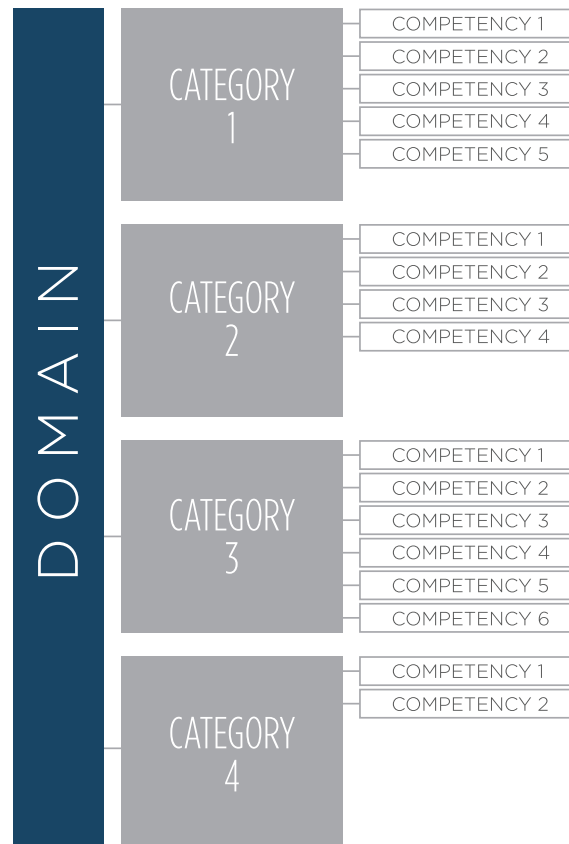
The ACLC research staff utilized a structured approach to identify a list of competencies for each domain. The first step involved the review of various frameworks and literature geared toward preparing providers to bear financial risk. Through a qualitative analysis, the staff identified common themes 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**

The quality domain is not defined to be limited to established quality measures. Instead, the domain has been principally defined to identify the essential and fundamental conceptual components of quality. The domain and categories are intended to be sufficiently broad to account for quality and safety from multiple perspectives and venues. Provider organizations that bear risk will need to understand and implement the related competencies in order to succeed. The quality definition proposed by the workgroup is:

***“Quality in health care is safe, effective, patient centered, timely, efficient, and equitable. It applies to patients and care delivery, operations and health care workers and is built on a culture that incorporates these similar principles.”***

### **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. Culture of Improvement (5):** Culture is the attitudes and behavior that are characteristic of a particular social group or organization including the discipline required by mental and moral training. In health care, the term ‘Just Culture’ is used to reflect a balanced accountability for both individuals and the organization responsible for designing and improving systems in the workplace.
- 2. Leadership (5):** A transparent, nimble, and balanced philosophy and teams to provide a clear vision, mission, and means to empower high-quality reliable care. Successful leadership permeates the organization at all levels and is constantly scanning over the horizon, proactively addressing quality care practices, and reactively responding as dictated by circumstances. Successful leaders are found in all levels of the organization, are adaptive and supportive, and apply best practice across the care continuum.
- 3. Operational Infrastructure (4):** Internal infrastructure for quality improvement within a health care organization ensures that it has the proper level of support for its successful conduct, beginning with senior leadership. The senior leadership team sets the quality improvement culture across the organization and enables the necessary resources to be properly trained and available ensuring that both clinical and operational teams are able to provide better care, while achieving an appropriate, achievable return on investment.
- 4. Measurement and Reporting (5):** Measurement is the identification of areas necessitating oversight and possible improvement; selection of measures that can reveal areas requiring improvement as well as highlight areas of high performance; identification of data sources; and analysis of results. Reporting includes both internal and external reporting — reporting of performance inside the organization as well as reporting to external stakeholders, including payers, patients, and partners. Reporting fulfills multiple goals such as marketing to patients or payers, aiding in negotiations, fulfilling regulatory and compliance requirements, and advocating for patients and their caregivers. It is worth explicitly stating that patients should be part of the team that develops and monitors the measurement and reporting framework.

**5. Integration Strategies and Partnerships (5):** According to the World Health Organization, an overall working definition of integrated service delivery is “The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.”<sup>9</sup> This requires a planned, collaborative approach with consideration of each stakeholder’s unique strengths and contributions, and the patients the organization serves.

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 quality workgroup has identified 24 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.

Beginning in 2010, Intermountain Healthcare began to formally develop a team-based care strategy designed to better enable the organization to provide population health management. The strategy and program consisted of building and assigning patients to a medical-home that included the integration of physical and mental health services. Related process and outcome measures were developed and reported for both patients that received Team Based Care (TBC) and those patients that did not.

Patients treated under the TBC model had higher rates of screening for depression, adherence to a diabetes care bundle, better hypertension control, and more direct involvement in documentation in self-care plans. They also had lower rates of emergency department visits and hospital admissions. The Team Based Care model also lowered the patients’ annual cost compared to those receiving normal care and total savings more than offset investments in building and implementing the TBC model.<sup>10</sup>

CATEGORY	COMPETENCY LABEL	COMPETENCY
<b>CULTURE OF IMPROVEMENT</b>	Q.1.1	Prioritize a culture of improvement at the board and senior management level
	Q.1.2	Develop organizational expertise in a specific and actionable improvement model
	Q.1.3	Commit to a transparent communication organizational strategy related to improvement efforts for all stakeholders
	Q.1.4	Ensure all staff are invested in a culture of improvement
	Q.1.5	Prioritize the creation and maintenance of a culture of safety applicable to all who interact with the organization

## Competencies (cont'd)

CATEGORY	COMPETENCY LABEL	COMPETENCY
<b>INTEGRATION STRATEGIES &amp; PARTNERSHIPS</b>	Q.2.1	Develop a process to collaborate effectively with value-focused partners across the health care spectrum
	Q.2.2	Ensure that patients, families, providers, and care team members are involved in quality improvement activities
	Q.2.3	Capture and report data relevant to cost, processes of care and care delivery, medical and health outcomes, and service outcomes in an integrated and standard manner
	Q.2.4	Build a team of operations and clinical quality improvement experts to guide the work of improvement teams in your organization
	Q.2.5	Develop formal capability whereby interdisciplinary clinical and operational teams can integrate with one another where necessary
<b>LEADERSHIP</b>	Q.3.1	Ensure that senior management and clinical administration are actively engaged in the operational functions of the quality improvement program
	Q.3.2	Develop leaders who are focused on quality improvement efforts at all levels of the system
	Q.3.3	Include the quality improvement program in the strategic plan of the organization, including representation in the budgeting process
	Q.3.4	Set meaningful and appropriate goals for your quality improvement efforts and monitor your progress towards those goals
	Q.3.5	Train all types of providers and employees in improvement theory, improvement methodology, and leadership
<b>MEASUREMENT &amp; REPORTING</b>	Q.4.1	Establish an enterprise data warehouse that has real-time clinical data (process and outcome), cost data, and service and safety data
	Q.4.2	Employ staff capable of leveraging the enterprise data warehouse for quality improvement activities
	Q.4.3	Develop a reporting tool, such as a dashboard, that captures appropriate deviations and benchmarks with public access
	Q.4.4	Monitor data integrity and conduct periodic data quality audits to ensure accurate data
	Q.4.5	Maximize the use of structured data obtained through consistent documentation
<b>OPERATIONAL INFRASTRUCTURE</b>	Q.5.1	Reward quality improvement successes throughout the organization
	Q.5.2	Invest in health IT that optimizes your quality improvement and patient safety efforts
	Q.5.3	Select clinical champions that demonstrate a commitment to value-based initiatives and quality improvement to lead each quality improvement efforts
	Q.5.4	Build the infrastructure and staff necessary to support quality improvement activities

## ▶ NEXT STEPS

The quality 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](https://AccountableCareLC.org).**

*“The quality information presented in this paper is a starting point and marks the beginning of a public comment period.”*



## ***Workgroup Members***

**Michael Udwin, MD**, *Accenture*  
**Rhonda Taller**, *American College of Cardiology*  
**Mary Copping**, *American Medical Association*  
**Carol Burkhart**, *Aon plc*  
**Daniel Belletti**, *AstraZeneca*  
**Candace Ramos**, *Children's Mercy Integrated Care Solutions*  
**Rene Cabral-Daniels**, *Community Care Network of Virginia*  
**Tina Pike**, *Conifer Health Solutions*  
**Diana Cardona, MD**, *Duke University School of Medicine*  
**Maggie O'Keefe**, *Health Catalyst*  
**Melissa Kurtz**, *Henry Ford Health System*  
**Patricia Wise**, *HIMSS*  
**Barney Hebert**, *HORNE LLP*  
**Timothy Ihrig, MD**, *Ihrig MD & Associates*  
**Jessica Savage**, *Integrated Health Partners*  
**Jeanette Waxmonsky, PhD**, *Jefferson Center for Mental Health*  
**Sophie Shen**, *Johnson & Johnson*  
**Susan Wood**, *Kansas Association for the Medically Underserved*  
**Paul Kaplan, MD**, *Lumeris*  
**Richard Sabbara**, *McKesson*  
**Alia Faiz**, *Medecision*  
**Elana Stair**, *Medtronic*  
**Josette Gbemudu**, *Merck & Co. Inc.*  
**Cheryl Modica, PhD**, *National Association of Community Health Centers*  
**Paul Casale, MD**, *NewYork-Presbyterian*  
**Jennifer Van Meter**, *Novartis Pharmaceuticals Corporation*  
**Ted Wymyslo, MD**, *Ohio Association of Community Health*  
**Jerry Grannan**, *Parkview Health*  
**Richard Bikowski, MD**, *Sentara Quality Care Network*  
**Seth Wolk, MD**, *Spectrum Health*  
**Mike Abbadessa**, *Takeda Pharmaceuticals U.S.A.*  
**Eddie Hagens**, *TriZetto*  
**Joan Valentine**, *U.S. Medical Management*  
**Jonathan Whitney, MD**, *WellSpan 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.

## ***Acknowledgments***

This white paper was developed by members of the ACLC Quality Workgroup, led by the chair, Dr. Todd Allen, and the managers Christopher Loumeau and Daniel Chipping. Members of the quality workgroup are listed above. Additional support was provided by the ACLC co-chairs, Governor Michael O. Leavitt and Dr. Mark McClellan, editors David Introcaso, John Poelman, and the host organization Western Governors University.

## ***Bibliography***

1. The Commonwealth Fund. US Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives [Internet]. 2014 [cited 2016 Sep 6]. Available from: <http://www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last>
2. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century [Internet]. Washington, D.C.: National Academies Press; 2001 [cited 2016 Sep 6]. Available from: <http://www.nap.edu/catalog/10027>
3. Chassin MR. Improving The Quality Of Health Care: What's Taking So Long? *Health Aff (Millwood)*. 2013 Oct 1;32(10):1761–5.
4. Erasmus V, Daha TJ, Brug H, Richardus JH, Behrendt MD, Vos MC, et al. Systematic review of studies on compliance with hand hygiene guidelines in hospital care. *Infect Control Hosp Epidemiol*. 2010 Mar;31(3):283–94.
5. McManus D, Pipkin SS, Whooley MA. Screening for depression in patients with coronary heart disease (data from the Heart and Soul Study). *Am J Cardiol*. 2005 Oct 15;96(8):1076–81.
6. Rickheim PL, Weaver TW, Flader JL, Kendall DM. Assessment of group versus individual diabetes education: a randomized study. *Diabetes Care*. 2002 Feb;25(2):269–74.
7. Advisory Board. The Essentials of Risk-Based Contracting [Internet]. [cited 2016 Sep 6]. Available from: <https://www.advisory.com/research/financial-leadership-council/white-papers/2014/the-essentials-of-risk-based-contracting>
8. James BC, Savitz LA. How Intermountain trimmed health care costs through robust quality improvement efforts. *Health Aff Proj Hope*. 2011 Jun;30(6):1185–91.
9. [service\\_delivery\\_techbrief1.pdf](http://www.who.int/healthsystems/service_delivery_techbrief1.pdf) [Internet]. [cited 2016 Sep 6]. Available from: [http://www.who.int/healthsystems/service\\_delivery\\_techbrief1.pdf](http://www.who.int/healthsystems/service_delivery_techbrief1.pdf)
10. Reiss-Brennan B, Brunisholz KD, Dredge C, et al. Association of integrated team-based care with health care quality, utilization, and cost. *JAMA*. 2016 Aug 23;316(8):826–34.