ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

COMPETENCY ORIENTATION GUIDE

Competency: Ensure effective transitions between care teams
Committee: The Committee on Care Transitions

AUGUST 2019

BACKGROUND

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization dedicated to accelerating the transition to accountable care by identifying the care delivery competencies needed for providers to succeed in risk-based payment models. The Competency Orientation Guides (COGs) serve as an overview of a particular competency and are intended to help break down the competency into more digestible aspects that could be implemented in a variety of ways. Each COG represents the distilled insights from the deliberations of a dedicated committee comprised primarily of leaders from provider organizations, industry partners, and ACLC research staff. In this case, this COG was developed by the Committee on Care Transitions which convened between March and May of 2019.

Competency Framework

Competency: Ensure effective transitions between care teams

1. Maintain collaborative relationships with strong partners across the care continuum
2. Establish transition protocols that include clear checkpoints and responsibilities for all involved
3. Provide access and ability to share all essential information

Competency Importance & Context

Succeeding in value-based health care requires the ability to effectively manage patient needs across the care continuum. A crucial component to this is facilitating successful patient transitions across care settings. Lack of coordination, communication, and patient engagement during care transitions can lead to poor health outcomes, preventable hospital admissions, and avoidable hospital or unnecessary post-acute readmissions. Disparities in provider resources, data tracking methods and systems, care models, and various other factors present challenges to standardizing such procedures across all care settings. This committee was convened to discuss the common challenges that face provider organizations and to compile best practices and other mechanisms for success in care transitions.

IMPORTANT TERMS

When discussing this particular competency, it became necessary to clarify who (if anyone) should be the focus of the patient feedback training efforts. The Committee agreed to use the term clinician when referring to those who provided actual care to patients, as opposed to the variety of staff that are also instrumental in providing the overall experience. It was concluded that, although clinical staff will certainly be responsible for the majority of the conversations around care per se, this competency applies to a much broader group of team members. Additionally, terms like Patient-Centeredness and Patient-Engagement were avoided in favor of using more self-evident and specific language that all could understand even though implementation discussions at an individual health care organization may necessitate defining those terms for internal discussions. [Note: should we link to our preferred definitions/sources for those terms regardless?

1. Maintain collaborative relationships with strong partners across the care continuum

Committee Insights:

- A care transition strategy benefits from a single point of coordination and accountability. Ideally, this is a person with stature and decision-making authority within the organization who can champion the necessary organizational and culture change. However, day-to-day coordination activities can and are often delegated.
- Building strong partnerships requires a high level of collaborative IQ. Partners should be actively engaged in discussions about expectations and measures of success and involved in decision-making regarding patient engagement and care.
- Utilize metrics, payment models, and other mechanisms to align goals across provider partners.

Challenges:

- Providers have different care models, payment models, and financial imperatives. Many of them still operate within traditional fee-for-service and may not be financially incentivized through value-based care models. Response: Convene collaborating stakeholders; establish shared vision and standards for care that ultimately serve patients.
- Downstream partners are busy and not always able to engage in multi-disciplinary teams or meetings to the extent that the ACO might like. Response: Develop cadence of regular check-ins via teleconference meetings or email checkpoints to inform and level-set with partner entities.
- Downstream partners may have different cultures, terminology, contracting norms, etc. Response: Establish a communication plan that facilitates a common understanding of key terms. Communicate via email, newsletter, and/or web-conference on a routine basis to build relationships, review expectations, and align incentives.

Potential Qualitative Competency Indicators:

- Identify specific elements of care transitions and measure how they deliver value via costs and outcomes
  - E.g., implementing regimented/standardized patient and family caregiver education at transition hand-overs and measuring its impact on readmissions.

2. Establish transition protocols that include clear checkpoints and responsibilities for all involved

Committee Insights:

- Successful transitions require a designated point person responsible for overseeing processes, communication, tracking, etc.
- Establish workflows for each member of the multi-disciplinary care team.
- Ensure that patients and caregivers are engaged in decision-making regarding the care plan, understand the care plan, and empower them to follow the care plan during and after the care transition.

Challenges:

- Large health systems can often be involved in several different arrangements for post-acute care, with all of them having different procedures, standards, etc. Response: Align processes to reduce burden on downstream partners.
- Staff are busy and some transition tasks get overlooked, particularly when there is a diffusion of responsibility among provider staff. Response: Establish and track protocols and workflows with clear steps for every stage of the process, assign responsibilities to care managers or other 'point persons', and establish simple turnkey instructions for completing them.
- Patients need to have accountability for their care plan and the decisions that may negatively affect their health outcomes. Response: Provide education to the patient and family to facilitate better decision making.

Potential Qualitative Competency Indicators:

- Documented procedures with a comprehensive step-by-step process for transitions within various scenarios available to all relevant employees
- Integration of transition process support into the EHR.
- Modulated staff trainings.

3. Provide access and ability to share all essential information

Committee Insights:

- Establish a clear partner communication strategy to make sure you are speaking the same language (i.e. have common understanding of key terms), are aligned on expectations for level and frequency of communication, and know how a patient will be tracked wherever they are on the care continuum.
- Align on what information will be shared about a patient or panel of patients and how.
- Assess IT capabilities and interoperability periodically. While most provider entities' data capabilities are getting more sophisticated, information flow is still disruptive and not all partners will have compatible systems.

Challenges:

- Interoperability of EHR, care management, etc. make it difficult to track where the patient is on the care continuum. Response: Implement an alternative communication mechanism if needed, such as regular meetings, a common care management platform, or dashboard software.

Qualitative Competency Indicators:

- Provider satisfaction with system's data sharing and interoperability.
- Measurable reduction of lags in patient health data/information access.
- Tracking readmissions and enacting interventions to prevent new ones.

GENERAL RESOURCES FOR FURTHER EXPLORATION:

Potential categories of resources:

- Agency for Healthcare Research Chartbook on Care Coordination, Transitions of Care
- Health Affairs and Improving Care Transitions

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