ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

COMPETENCY ORIENTATION GUIDE

Competency: Incorporating patient direction and feedback into care delivery efforts
Competency: The Committee on Patient Experience*

JULY 2020

BACKGROUND

The Accountable Care Learning Collaborative 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-bearing payment models. The Competency Orientation Guides (COGs) give 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, but also industry partners, and ACLC research staff. In this case, this COG was developed by the Committee on Patient Experience (the "Committee") which convened between January and May of 2019.

Competency Framework

Competency: Incorporate patient direction and feedback into care delivery effort

1. All staff serve as agents of patient feedback by being:
   A. Familiar with the needs of specific subpopulations and corresponding engagement opportunities
   B. Able to access and use essential information to engage patient
   C. Equipped to leverage communication strategies appropriate to the situation
2. Supported by infrastructure for systematic patient input**
3. Informed by and educated through institutional mechanisms for patient feedback integration**

COMPETENCY IMPORTANCE & CONTEXT

Despite near universal support for placing the patient at the helm of their care experience, concepts like patient-centeredness and patient-engagement tend to be ambiguous and all-encompassing making practical application difficult. To make the concept more approachable and concrete for health system leaders, the Committee, through a combination of pre-session interviews and group discussions, broke the competency down into three main sub-competencies (enumerated below), and chose to focus on preparing all staff to serve as agents of patient feedback (and of course within their scope of authority and responsibilities). The second and third sub-competencies were recognized as important, and likely even pre-requisites, but not as much in need of this particular group's contribution. A crucial underlying belief in our narrowed focus is that patients are the most important member of the care team and that our current system is not designed to give a voice to their direction and preferences. Therefore, if an organization is to leverage the patient's potential to influence their own care and outcomes, all staff will need to be given the tools and education to serve as agents of continual patient feedback.

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?]

COMMON ELEMENTS

A: Familiar with the needs of specific subpopulations and corresponding engagement opportunities

Committee Insights:

- Patients' needs vary widely depending on condition, disease stage, setting, etc., and so everyone on staff will have some role (limited by responsibility and authority) in giving the patient opportunities to positively influence their own care pathway.
- Since the opportunities for patient feedback vary greatly, there needs to be a common understanding of what it means for each employee to form a meaningful part of the crucial patient feedback loop.
- Review efforts should be informed by a thoughtful consideration of racial inequities in care outcomes as well as the unique clinical and nonclinical needs of other subpopulations (e.g. the LGBTQ community).
- Each organization will benefit from a systematic review of their care continuum and identification of the categories of opportunities for patient feedback and real-time feedback integration.
- There will always be patients who don't fit into any generic care category and their needs are likely to be high; an additional review should be done with various patient profiles in mind.
- Clinicians still oversee the majority of direct feedback opportunities and will necessarily be the focus of any training efforts.

Challenges:

- Ingrained clinical philosophy to treat all patients the same could result in push-back for programs that appear to give special treatment to a group of individuals. Response: Demonstrate how treating patients the same can result in sub-optimal care for patients with special needs.

- Programs to implement this competency could require significant upfront financial outlays without a direct or immediate return on investment. Response: Many of the organizational skills developed to work with one subpopulation are transferable to other subpopulations effectively distributing the cost overt time.

Potential Qualitative Competency Indicators:

- Percentage of patients with an indication (chart or EHR-based) of specific subpopulation needs
- Percentage of staff having undergone subpopulation training program(s) (see Lifebridge Cast Study Brief)

B: Able to access and use essential information to engage patient

Committee Insights:

- Staff needs to have quick access to information like demographic data, health literacy indicators (e.g. patient activation measure (PAM) score), and other relevant (e.g. SDOH-related) information in preparation for their patient encounters
- Staff need to be oriented to particular language preferences of a patient to ensure open and clear communication
- A thoughtfully designed support system can free up clinicians to focus their energies on a patient's more unique needs. A good system can pick up on needs that obviates the requirement for clinicians to ask everyone about a specific issue.
- Electronic health record systems need to easily incorporate and prioritize (via display) patient preference information

Challenges:

- Clinicians are already faced with an information overload. **Response:** The case will need to be made that this information will have an outsized impact on patient satisfaction and important clinical outcomes.

Potential Qualitative Competency Indicators:

- Percentage of patients with an indicator of health literacy (e.g. PAM score)
- Percentage of patients for whom social determinants of health have been assessed and documented
- Percentage of clinicians trained to leverage patient engagement information
- Percentage of clinicians accessing patient engagement information (e.g. portal module usage statistics).

C: Equipped to leverage communication strategies appropriate to the situation

Committee Insights:

- Using case studies and role playing in training can be an effective use of demonstrating a variety of situations and appropriate staff responses
- Hiring communication personnel from within the specific subpopulation being served can be an effective way to "bake in" the intended patient voice
- Communication trainings will benefit from smaller groups both for the pilot benefits of refining the educational tools prior to broader deployment but also ensuring an intimate group size and safe space for asking important but sensitive questions

Challenges:

- Often times capacity to care for sub-populations already exists but getting the word out is difficult. Response: A robust marketing campaign to make the community aware of these efforts can help justify the efforts through increased (but appropriate) volume.

Qualitative Competency Indicators:

- Patient-engagement personnel from the targeted community on staff or readily available for consultation (Y/N)
- Percentage of clinicians with shared decision-making training

GENERAL RESOURCES FOR FURTHER EXPLORATION:

- Office of Disease Prevention and Health Promotion, Health People 2020, Social Determinants of Health
- Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. Health Serv Res. 2004
- Strategy 6I: Shared Decisionmaking. Content last reviewed October 2017. Agency for Healthcare Research and Quality, Rockville, MD.

*Hyperlinked to Committee landing page with full committee-developed resources and contributors
**Sub-competencies to be considered in future committees

Committee funding supported through member-sponsorship from the following:

NOVARTIS capc Center to Advance Palliative Care HealthEquity