Publication Development Guide – Quality Workgroup

OVERVIEW

- **ACLC's Mission**: Accelerate the adoption of a range of accountable care delivery models throughout the country
- **ACLC's Vision**: Create a comprehensive list of competencies that a risk bearing entity will need to succeed in a value-based payment environment

APRIL 2016 IN-PERSON MEETING

On April 27, 2016 the first in-person meeting of the Accountable Care Learning Collaborative (ACLC) – Quality and Process Improvement Workgroup was convened in Washington, DC. The workgroup focused its discussion on meeting objectives as outlined below. This guide will provide a summary of the objectives discussed, progress made on the objectives, and list the meeting attendees and workgroup members.

ACLC Quality and Process Improvement Workgroup In-Person Meeting Objectives

- *Review domain name:* Discuss domain name "Quality and Process Improvement" and decide whether the name is appropriate or should be revised.
- *Identify and Define Categories of Competencies***:** Guided by the ACLC's framework and literature review of quality and process improvement, the workgroup will develop a list of categories of quality competencies and descriptions for each category.
- *Identify and Define Competencies:* Specific competencies for each category will then identified. Competencies will be refined, and terminology will be defined as needed.

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PROGRESS: The progress related to each objective is outlined below.

Domain Name

The in-person participants reviewed the domain name and considered the meaning of both quality improvement and process improvement. It was suggested that process improvement is not accurate for the domain name as it is most often the means, or method, of achieving consistent healthcare quality. Also, the group considered adding patient safety to the name as it is such a critical piece of care and is given a high level of focus in the industry currently. It was debated that an organization cannot have quality without also having safety. Likewise, it was felt that the term "Culture" should not be included in the domain name as it will likely appear as a competency and the term is in the title of another domain name relevant to this project.

As of May 30, 2016 the proposed domain name is: Quality and Safety

Domain Definition/Description

Categories and competencies relevant to the domain "Quality and Safety" in healthcare remain consistent with previous standards and publications. The domain describes the essential conceptual components of quality rather than limiting to measured indicators and is therefore broad enough to account for quality and safety towards multiple needs. Quality in healthcare care is safe, effective, patient centered, timely, efficient, and equitable. It applies to patients and care delivery, operations and healthcare workers and is built on a culture that incorporates these same principles. Organizations that bear risk will need to understand and employ the relevant competencies in order to succeed toward their goals.

Categories

Many ideas were discussed and captured and the refined list shows the major elements of quality as identified during the meeting. The participants recognize that the categories put forth are a draft which will spur a conversation within the larger workgroup.

The following two tables summarize the current view of categories that map to the domain of Quality and Safety. These categories were derived from discussions during the in-person meeting:

The first column in the first table maps categories initially identified by the ACLC research team as potential categories of competencies to those derived by the workgroup during the in-person meeting. Those categories are listed in the second column of the first table. The in-person participants developed their list of categories without being aware of the original list developed by staff members and researchers of the ACLC. The process began as a brainstorm of ideas as the participants considered their own experience in quality and tried to identify the major components.

Original List of Categories of Care Coordination Competencies	Workgroup's Refined List
HIT	Measurement and Reporting
Metrics	
Output	
Organization	Internal Infrastructure
Team	
Process	Integration Strategies and Partnerships
Structure	Leadership
	Culture and System of Improvement

The second table below shows each category (first column) as derived during the in-person meeting, an accompanying category description generated by a few of the in-person participants (second column), and a few representative competencies that will likely map to each category (third column). Categories and category descriptions will continue to evolve as the larger workgroup is able to review the work to date. It is also expected that additional and a formal list of competencies will be added

as the workgroup shares and reviews existing assessment tools and literature and after the categories and their definitions have been finalized according to the workplan.

Proposed Refined Categories	Description of Category	Relevant Competencies (representative, not comprehensive)
Leadership	Leadership: A transparent, nimble, and balanced philosophy and team 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 all dimensions of care. [alternate end…apply best practice across the care continuum.]	• Chief office or senior leader creates energy, synergy and focused leadership for QI program • Leaders develop a strategic quality plan that identifies clear goals, is fact based, includes systematic cycles of planning, execution and evaluation, concentrates on key processes, and focuses on patients and other stakeholders • Create and support an infrastructure that organizes and supports the work
Measurement and Reporting	Measurement is the identification of areas of needed 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	• Collect structured data • Finance and clinical departments understand and agree upon metrics that should be tracked • Aim statements (project goals) are created • Provide performance reports to providers, administration, and other stakeholders • Make quality and price information readily available to, and digestible by, patients and their families

	partners. Reporting fulfills multiple goals such as marketing to patients or payers, aiding in negotiations, fulfilling regulatory and compliance requirements, and advocating on behalf of the organization.	
Culture and System of Improvement	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. Reference: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3776518/ System of Improvement- this model would allow for problems to be defined, analysis completed, solution convergence with implementation. Continual feedback necessary to assure problem is addressed and changes are made as necessary to assure quality outcomes are achieved. (used to solve difficult social problems- this system will support the culture).	• Organization is able to honestly assess current culture and commitment to QI • System has a steadfast, long-term commitment to common healthcare quality goals • QI activities are cyclical and seek higher levels of performance in each iteration • Ability to break down larger initiatives into smaller ones • After successful implementation of a change for a pilot population, disseminate change to remainder of the organization • Communicate changes, challenges, and progress to all stakeholders affected. • Engineering principles and human factors analysis should influence the design of health care systems so they are safe and reliable.
Internal Infrastructure	Internal infrastructure for Quality Improvement within a health care organization would ensure that it has the proper level of support for its	• System has technological, human, physical, and financial assets to carry out QI initiatives • Invest in HIT systems that can monitor progress,

	successful conduct, beginning with senior leadership. The senior leadership team sets the culture of Quality Improvement 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 ROI.	evaluate performance, and make real-time program adjustments based on findings • Establish reasonable budgets and time frames for each initiative • Invest in QI infrastructure including learning, data collection, data analysis
Integration Strategies and Partnerships	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." This requires a planned, collaborative approach with consideration of each stakeholder's unique strengths and contributions. Reference: http://www.who.int/healthsystems/service_delivery_techbrief1.pdf	Core ACO integration strategies include: • Developing the legal and organizational structure • Developing a physician-driven governance (board and committees) model • Identifying and nurturing physician leadership • Assembling, monitoring and policing the provider network • Developing a care model using evidence-based protocols to support population health management • Implementing disease management strategies for high-cost patients • Distributing financial incentives to participating providers • EHR connectivity and integration • Data collection, analytics and reporting

MAY 2016 CONFERENCE CALL

Since the in-person meeting, the workgroup has been able to meet via a conference call to review the work to date, which has included the creation of this Publication Development Guide. The group discussed the major sections of work that are being addressed. The Major components, along with updates on each, are as follows:

Terminology: The workgroup did not address the terminology goals of the ACLC, which are to:

- Identify terminology that if left unclear makes the work more difficult
- Create clear definitions for the use of the terminology in ACLC publications, including competencies

Domain Name: The workgroup did not make further changes during the call

Domain Description: The workgroup did not make further changes during the call

Category Selection: The workgroup reviewed the categories listed above and made no changes

Category Descriptions: The workgroup reviewed the category descriptions, and since the call have submitted additional language for consideration. The category descriptions herein are updated to reflect the most current content.

Competencies Refined: The workgroup did not review specific competencies as that section of the work is scheduled for July 2016 through September 2016.

The Quality and Safety workgroup will review and make edits or additions to this version of this document during the week of May 30 to June 5, 2016. An updated document will then be prepared and circulated for work during the June 8 in-person meeting.