VALUE-BASED HEALTH CARE: ATLANTA PILOT

Importance of this Pilot:

The Atlanta Value-Based Health Care Pilot is aimed at launching a value-based healthcare model that improves outcomes and reduces costs for heart failure patients who receive care in facilities located in Cobb, Fulton, or DeKalb counties. This project marks the first time multiple major health systems and payers in the Atlanta market are working together and jointly engaging a network of non-clinical community service providers in metro-Atlanta.

This multi-system, multi-payer pilot will align, track, and benchmark outcomes on a neutral platform and center patient outcomes in all phases of the project. It also shifts funding to support quality and not quantity of care. While heart failure is the current focus, the infrastructure built through this effort is designed to address additional health conditions appropriate for a value-based relationship.

This is a 5 year pilot, implementing and refining the model in years one and two and executing value-based payment contracts between health systems and payers in years three through five.

Goals:

The ambitious but achievable goals of this pilot:

- Improve quality of care for heart failure patients in Atlanta through the linkage of social supports and clinical care
- Standardize data collection across health systems, including post-discharge care
- Reduce readmission rates for patients with chronic heart failure
- Reduce costs for health systems and payers
- Improve patient reported outcomes
- Institute value-based payments that incentivize better patient outcomes and lower healthcare costs.
- Share best practices across local health systems

Assumptions and Guiding Principles:

In addition to our stated goals, the pilot has a number of assumptions and guiding principles:

- Mitigate risk on all sides
- Minimize data collection and entry by building on existing EMRs and other data and data sharing systems
- Only collect data that has a purpose and in a format that can be analyzed
- The current drivers of poor quality and high cost can be traced to the lack of and connection to social and community supports for heart failure patients; this project's emphasize will remain on these connections, leaving any changes to clinical practices to individual health systems.

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- Currently negotiated contracts between health system and payers will continue to exist, this project only seeks to inform future contracts and payments

Activities:

In order to implement this pilot, the program team is focusing on six main activities:

1) Data standardization, which includes reconciling existing data collection at each health system, adoption of the ICHOMS Heart Failure dataset, obtaining any necessary licenses (such as for the KCCQ12), and building any additional data fields into the EMR.
2) Data Collection, which begins with 3 months of baseline data collection using the ICHOMS (International Consortium for Health Outcomes Measurement) heart failure dataset and a few additional key outcomes. Because many health systems are not quantitatively capturing information around the social determinants of health (and therefore, have data that is not easily searchable), we want to collect standardized data that will inform risk stratification activities.
3) Baseline data analysis, which includes reviewing baseline data, stratifying by age/race/insurance coverage/other SDH factors, calculating risk ratios and logistic regression models, and making recommendations for risk stratification.
4) Risk stratification, which is tied to the baseline data analysis and includes developing risk models and informing intervention activities.
5) Implementing an intervention that improves post-discharge care for heart failure patients. We've initially identified the Coleman Transitions Model as a possible intervention. The Coleman Care Transitions model focuses on the first 4-weeks post-discharge, and is designed to help patients with medication self-management, guide them through the care process, help with following-up with a primary care provider or specialist as instructed, and help patients identify red flag indicators of worsening conditions and next steps. Additional intervention activities include identifying gaps in current care transition work, modifying intervention activities based on risk stratification findings, and modeling and testing a payment model.
6) Developing a Catalog of Social Support that is comprehensive and specific for heart failure patients. This Catalog will be virtual and updated regularly and will initially provide information on assistance around prescriptions, transportation, financial resources, stable housing, and support care.

Phase 1:

During Phase 1, Emory Healthcare, Grady Health System, and WellStar Health System will launch a coordinated data collection phase. There are an estimated 6,000 heart failure patients with an inpatient stay across these three systems, and having all three launch at the same time will allow for robust data collection for the baseline analysis. Data collection will include the measures outlined in the ICHOMS dataset but will also include information about heart failure stage and other demographic measures. Launch is scheduled for summer of 2019, and baseline data collection will continue for three months.

Once baseline data collection has concluded, the pilot will quickly turn to risk stratification to inform intervention implementation, currently scheduled for fall of 2019.The first goal identified by the

partners is a reduction in readmissions but future goals can include medication management as well as disease progression and regression.

A payment model, currently under development, will fund the intervention during the first two years of implementation and reward systems that achieve the pilot's shared outcomes and goals.

Phase 2:

Phase 2 will expand the knowledge learned during Phase 1 to other health systems, such as Piedmont Healthcare and Northside Hospital. Phase 2 health systems will draw on the experiences of the Phase 1 health systems to accelerate their entry into the pilot.

Phase 3:

Phase 3 of this pilot will solidify the infrastructure built within participating health systems and payers to allow re-negotiation of contracts integrating a value-based payment model designed to improve outcomes and reduce costs of heart failure patients.

Leadership :

The project is co-led by the Atlanta Regional Collaborative for Health Improvement (ARCHI) and the Metro Atlanta Regional Office of the American Heart Association. The leadership team also includes the benchmarking and intervention lead agencies, the Atlanta Regional Commission, the City of Atlanta and the Georgia Health Information Network.

Partners participate actively in workgroups focused on the major activities detailed above. An Executive team of vested partners guides decision making for the overall effort.

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Signed Partners:

American Heart Association
ARCHI
Atlanta Regional Commission
Blue Cross Blue Shield
Boston Consulting Group
Centene
City of Atlanta
DeKalb County Board of Health
Georgia Department of Public Health
Emory Healthcare
Georgia Health Information Network
Grady Health System
Home Instead Senior Care
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