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Atlanta Value-Based Health Care Heart Failure Pilot

An evaluation of a collaborative approach to develop of a value-based payment model

October 2020

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EXECUTIVE SUMMARY

The Atlanta Value-Based Health Care Heart Failure Pilot Collaborative (VBHC HF Collaborative) was formed in June 2017 for the purpose of designing a value-based payment system as a pilot aimed at improving health at the population level. Collaborative partners met monthly while workgroups met more frequently for three full years, generating a number of products and achieving some success. The collaborative identified and catalogued social support resources, built relationships and new partnerships, shared best practices for care for congestive heart failure (CHF) patients, focused on the social determinants of health (SDOH) and the impact of social supports on clinical outcomes, and created a coalition that could be a potential vehicle for other areas of collaboration. However, the collaborative was unable to move from planning to implementation of the value-based payment plan, even in a scaled down form.

The Atlanta Regional Collaborative for Health Improvement (ARCHI), a partner in leading this work, conducted an evaluation of the VBHC HF Collaborative work using document review and key informant interviews in order to understand how members viewed the collaborative work, the promise of value-based payment models in addressing the SDOH, and the barriers partners perceived to implementation. Additionally the evaluation identified accomplishments, challenges, and recommendations.

Stakeholders note several facilitators that supported this work, but the inability to get to implementation appears to be driven by barriers related to financial risk and lack of consensus around the data. Moreover, changing federal policy and local political priorities changed the incentives for participation among the partners, reducing urgency around the work.

Specific challenges included:

- Fluctuations in membership and in level of commitment among members
- Decision making and governance processes that changed over time and did not prioritize the most committed members
- Competitive relationships that restricted the ability or willingness to share information
- Existing value-based contracts that were not specific to CHF and were proprietary
- Inclusion of patients covered by nonparticipating payers or no source of payment, coupled with efforts to pool funds from payers with varying ability to use revenue for this type of innovation
- Wide variability in costs and timelines for modification to existing electronic medical record (EMR) systems to integrate the adopted ICHOMS dataset.

Recommendations include:

- The need for ongoing strategic management of coalition membership and attendee decision making authority

- Explicit alignment of decision-making rights and access to information with commitment to the work, willingness to share the financial risk, and assurances of confidentiality
- Initial funding for population-based initiatives requires seeking unrestricted funds, such as community benefit or foundation funding
- The need for inclusion of public payers and public payment models in the value-based design
- The use of a minimum dataset that aligns with partner organizations' existing EMR.

INTRODUCTION

The Atlanta Value-Based Health Care Heart Failure Pilot Collaborative (VBHC HF Collaborative) was formed in June 2017 in response to the Value in Health Care Initiative (ViHC) of the World Economic Forum (WEF). The ViHC initiative was designed to identify communities across that globe that could engage in innovations around enhancing the value of health care in their communities. With the strong support of the mayor's office, Atlanta was chosen as a pilot site for this initiative. The mayor's office convened key stakeholders including providers, payers, home health care organizations, and social support agencies. A detailed listing of stakeholders can be found in Appendix 1. This multisystem, multipayer group signed a commitment to work collaboratively and in innovative ways to design a value-based health care pilot aimed at improving health at the population level.

Because of the high local prevalence of congestive heart failure (CHF) and the high cost of CHF readmissions, the collaborative wanted to focus their work on CHF patients. Each of the collaborative organizations sought a greater understanding of their CHF populations and this initiative provided an opportunity to understand CHF at a population level. The anticipated value-based model would include all CHF patients in Dekalb, Fulton, and Cobb counties, regardless of payer or provider. The collaborative also determined that payments should be tied to the 30-day readmission rate. Because readmission was selected as the benchmark for payments, the collaborative focused on interventions to address nonclinical barriers to health, including the social determinants of health (SDOH) that can be critical during the 30-day, postdischarge window.

The decision to work collaboratively in a multistakeholder coalition and to focus on the role of SDOH as a target for increasing value was consistent with the literature and the ongoing national conversations about value-based care. Peer reviewed research and published whitepapers alike highlight the value of collaboration to improve care and address population health (Avalere, 2013; Deloitte, 2015; Thomas, 2017; Sweeney et al., 2018; Pendleton, 2018).

HISTORY OF THE COLLABORATION

The WEF engaged the Boston Consulting Group (BCG) in June 2017 to support the development of a roadmap for the collaborative work. Over the course of six months, BCG facilitated a high-level plan for the pilot that included data standardization across health systems, benchmarking to identify variation and share best practices, and an evidence-based intervention that addressed barriers to successful care including compliance, medication access and reconciliation, and SDOH. Together with BCG, the collaborative created workgroups that focused on data collection and sharing, development of an intervention, and development of a payment model. The high-level action plan that the collaborative created included:

- Standardized data collection using the International Consortium for Health Outcomes Measurement (ICHOMS) CHF dataset
- Data consolidation and benchmarking by the Georgia Health Information Network (GaHIN)
- Improve quality of care for heart failure patients in Atlanta through the linkage of social supports and clinical care
- Use of the evidence-based Coleman Model intervention to address social support and nonclinical issues in the first 30-days post-discharge
- Institute value-based payments that incentivize better patient outcomes and lower health care costs
- Focus on the approximately 6,000 CHF patients being cared for by participating health systems.

The goals identified by the collaborative were:

- Reduce readmission rates for CHF patients
- Reduce costs for health systems and payers
- Improve patient reported outcomes.

After completion of the roadmap, BCG turned the program management and implementation planning back over to local partners. The mayor's office and the VBHC HF Collaborative partners recognized the need for neutral leadership for this complex project. Therefore, they invited the Atlanta Regional Collaborative for Health Improvement (ARCHI) and the American Heart Association (AHA) to facilitate the work of the collaborative. GaHIN was brought in to provide technological solutions to data collection, compilation, and benchmarking. ARCHI, AHA, and GaHIN made up the leadership team for the VBHC HF Pilot, with ARCHI staff assuming project management responsibilities.

Once this governance structure was in place, the WEF and BCG stepped back from the pilot, leaving development, implementation, and ongoing evaluation to the collaborative. The WEF continued participating in monthly advisory sessions through March 2018 and participated in several in-person executive committee meetings in 2018, but largely withdrew from any direct participation by early 2019, as their original plans for pilots around the globe had changed.

The leadership team took responsibility for scheduling meetings, following up with collaborative members, and moving the work forward. The project was conceived as a five-year pilot that would co-design the model in Year 1, implement and refine the model in Year 2 and 3, and execute value-based payment contracts between health systems and payers in Year 4 and 5.

The VBHC HF Collaborative created a number of assumptions and guiding principles for the shared work. These guiding principles were designed to ensure that the work followed agreed-upon guidelines and to highlight shared areas of agreement. These principles, shown below, guided the work of the collaborative throughout the three years.

The VBHC HF Collaborative sought to:

- 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
- Emphasize the connection between social and community supports and poor quality, high cost care, while leaving changes to clinical practice to individual health systems
- Leave negotiated contracts between health system and payers unchanged but inform future contracts and payments.

Five of the VBHC HF Collaborative partners combined resources to support staffing and the facilitation, research, and technical expertise needed to move the from the high-level goals to the detailed project plan and payment model design necessary before the project could be implemented. Program staff spent the next six months taking the high-level roadmap that BCG created and adapting it to the local environment. There were several areas that proved to be sticking points in adapting the roadmap, namely adoption of the ICHOMS dataset (for providers), the considerable upfront investment required to bring the project to scale, and the development of a payment model that did not interfere with current payment models (for payers).

Meeting Structure

The monthly meetings that started in 2017 evolved over time. Initially, the collaborative met as a whole to gain consensus around the intervention and data collection. Once the work moved into specifics around data builds, intervention implementation, and the development of a payment plan, smaller workgroups formed. The larger executive committee met monthly, while payers and providers met separately between September 2018 and October 2019. Payers focused on building a potential payment model and providers focused on refining the patient population and Coleman Model implementation. ARCHI provided shuttle diplomacy during this time, carrying ideas and feedback between the two groups, and adding additional research, data analysis, and model development where needed. Project staff worked one-on-one with partners to address information sharing concerns or discuss setbacks as they arose.

During this time, the collaborative produced a number of strong products. The payers developed a payment model that proposed bonus payments based on 30-day readmission rate. With payer feedback, the potential funding available for the pilot was scaled down, requiring the providers to identify a smaller target patient population with a focus on those most likely to readmit. That team developed a decision tree for implementation within their organizations.

The separate workgroups identified players who were missing from the collaborative. There were several major payers, including Medicare, that had not signed up as part of the collaborative during the initial call from the mayor's office. Project staff spent considerable

time reaching out to unrepresented payers who were not part of the collaborative, providing briefings on the work and inviting them to join. Ultimately, project staff was able to bring two additional payers to the table, but the payers for the majority of CHF patients in the Atlanta market remained unrepresented.

Late in 2019, the collaborative again started meeting jointly. It became clear that while the individual workgroups had made strong progress, the goal of shared work was becoming less and less viable. The collaborative could not reach consensus on the funding source and timing of the value-based payments, on widespread implementation of the ICHOMS dataset, or on the inclusion of patients whose coverage was not represented in the collaboration (mainly, Medicare and Medicaid). One health system was ready to implement while the others required a considerable investment of time and money before they could participate. Two payers were able to consider direct investment but did not have a direct path to do so and needed more time.

In January 2020, the collaborative realized that the design work had gone as far as it could and that implementation would have to wait until additional investors could be identified and engaged. Despite the progress in communicating across payers and providers and sharing best practices, the group paused planning for implementation of the multisystem, multipayer pilot, as originally envisioned. Should the circumstances of any of the individual health systems or insurers change, or if advancements in value-based health care practices and models advance at the federal or state level, the work completed by the collaborative would position this group to take advantage of emerging opportunities.

ATLANTA VALUE-BASED HEALTH CARE HEART FAILURE PILOT COLLABORATIVE

To better understand multisystem, multipayer collaborative work as a means to implement value-based payments to improve population health, an evaluation of the VBHC HF Collaborative is provided here. The evaluation was conducted for a number of reasons. It was important to understand how the members viewed the collaborative work, understood the promise of value-based payment models in addressing the SDOH, and perceived the barriers to implementation. It was also critical to highlight stakeholder perceptions of accomplishments to date. Finally, the evaluation identified key challenges and a set of recommendations and strategies to address these challenges.

Evaluation Methods

Standard qualitative evaluation methods included a document review of meeting agendas and minutes, examination of membership over time, identification of key decision points, and the evolution of the collaborative conversation. This information was used to develop and influence the Key Informant Interview Guide. Semi-structured interviews with collaborative stakeholders were conducted between May and August 2020. Interviews were recorded and transcribed. Multiple researchers used keywords to search for themes in the responses across areas of focus. Stakeholders were chosen through purposive

sampling in order to gather feedback from across sectors. Respondents also represented differing levels of commitment and time with the collaborative. A summary of interviewees is below.

Interview Summary		
Sector	**Number of Interviews Completed**	**Declined**
Provider	4	1
Payer	3	2
Implementation Partners	3	0
Totals	11	3

The stakeholder interviews focused on five main areas:

- Definition and expectations of shared work and commitment
- Expected goals of the HF Pilot
- Perceived accomplishments and achievements along with barriers to success
- Discussion of value-based payments, CHF, and SDOH
- How to move forward.

Findings are organized around two areas of focus:

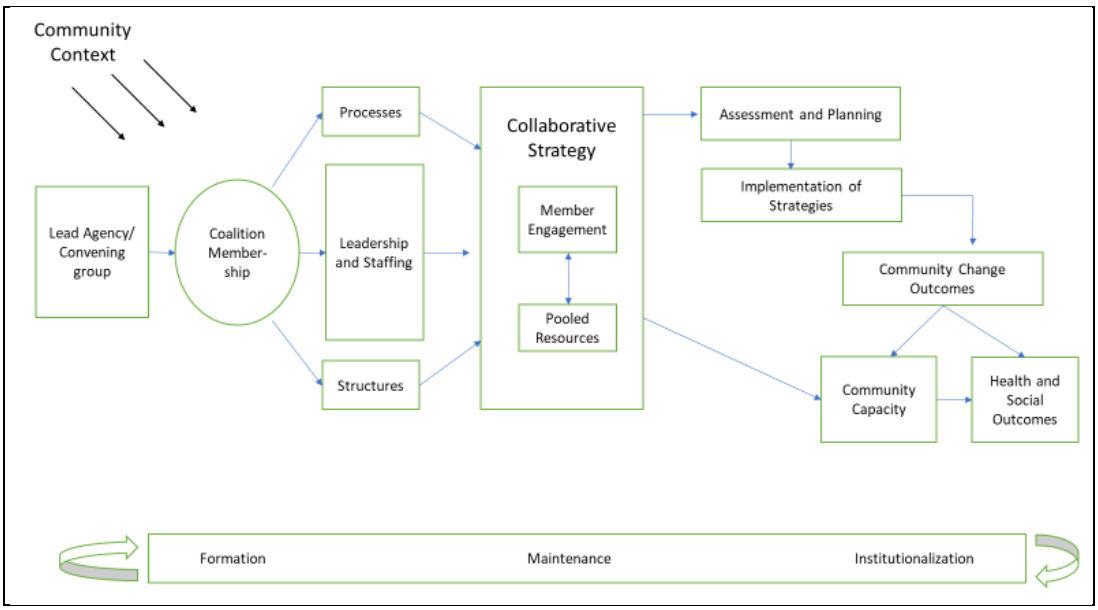
- The formation and maintenance of the collaborative in order to improve understanding of the ways in which diverse organizations can come together around a joint purpose or problem to drive change at the community level.
- The specific strategy pursued by the collaborative around value-based reimbursement across providers and payers as a tool to address SDOH. Early on, the members of the collaborative determined that they should focus on using value-based payment models as a tool to enhance access to social and community supports for CHF patients as a means of lowering readmission rates and improving health outcomes across the city.

EVALUATION OF THE COLLABORATIVE

The theory of change stated that designing a payment system to address outcomes that are driven by community resources and SDOH is beyond the reach of a single health system or payer. Working alone, there was not enough incentive for any one system or payer to invest in the needed infrastructure and partnership needed to achieve results. Additionally, if any one system or payer were to invest and build out the clinical to nonclinical referral and support network, all the others could benefit. As a result, a multipayer, multiprovider collaborative was required for this purpose.

The increase in collaborative work over the last few decades has resulted in a growing body of literature that assesses their development and effectiveness, and identifies the factors that contribute to collaborative stability or perceived successes and failures of the work. Butterfoss and Kegler (2009) enhance understanding of how collaboratives function in practice by drawing on the practical experiences to create a theory of community collaboratives. This theory has been used over the past decade for evaluations of community work in multiple contexts (Kegler, Rigler, & Honeycutt, 2010; Flewelling & Hanley, 2016; Cardazone, U Sy, Chik, & Corlew, 2014; Payán, Lewis, Cousineau, & Nichol, 2017). The Butterfoss Community Coalition Model was used as a framework for evaluating how the collaborative came together (formation) and maintained its work over time (maintenance).

Figure 1: Butterfoss Community Coalition Model



Butterfoss and Kegler, 2009.

Community Context

Heart failure remains one of the top challenges for health systems in metro-Atlanta. The local context motivated this collaborative to address heart failure in Atlanta through an innovative approach that would change how heart failure is treated and improve the life expectancy of people. This pilot also marked the first time that multiple payers and providers collaborated to address the health care needs in Atlanta. The challenges of collaborative work were expected to be high in this context, given the nature of the partners who were brought to the table. Payers and providers often see the other as competitors, and are typically engaged in tough negotiations around payments.

Formation: Convening

The high profile and visibility of WEF brought several of the organizations to the table as participants in this work (one respondent specifically noted that they "got involved because of WEF"). The evaluation notes that the value of a convener with high visibility (WEF) and authority and political capital (mayor's office) to pull diverse and competing organizations together cannot be understated.

Several of the VBHC HF Collaborative partners brought seed money for pilot development to the project as an initial resource to begin the collaborative work. However, many of the partners believed that the WEF as the convener would be providing sufficient resources to move the pilot through to implementation. Interviews confirmed the communication challenge around the distinction between convening and funding. One interviewee was explicit that there was an assumption that the WEF would be providing resources and "not the other way around." One member cited the high level of support from the conveners as critical.

The value of a high-profile convener comes with a cost. For example, there was some sense among members that the convener's agenda was not completely aligned with the collaborative members' agenda ("WEF tried to mold us into what they wanted"). Other participants came to the collaborative because of the conveners, despite not being wholly invested in the purpose of the work.

Synthesis of stakeholder feedback suggests that while a strong convener brought partners together, it did not ensure that all partners were similarly invested in the purpose of the collaborative. Clarity about the extent of startup resources from the convener is critical to setting up collaborative expectations.

Formation: Purpose

The Butterfoss Model is silent on the role of purpose in collaborative formation, but this work highlights the importance of purpose. In this case, the purpose was established by the conveners, preceding collaborative formation. Participants focused that purpose by establishing a strategic direction around community supports and SDOH. The clear purpose was helpful in drawing in and adding partners over time. However, some members suggested that the purpose was sufficiently vague as to promote inclusion of members who were not fully invested in the work. One member indicated that they had "high expectations for a well-intentioned project," but that the focus on community benefit was a challenge since it would have no direct "benefit to our organization."

Moreover, the value of the project was never clearly related to the business model of participants. One organization "questioned if the return on investment [ROI] was worth it but kept participating" while another "struggled with how to commit resources that would not directly benefit our patients." Some members identified alternative purposes or potential purposes for the collaborative such as sharing of patient information across delivery systems, enhanced learning about payment models, or innovation.

Stakeholder feedback supported the role of a broad purpose in bringing partners to the table. However, as the proposed benefits extend diffusely across the community, it became increasingly difficult for participant organizations to justify the investment of resources (particularly money) in the collaborative. There was general agreement that the purpose of the collaborative can change over time, creating intermediate benefits and outcomes in the implementation of larger goals.

Formation: Membership

The evaluation shows the importance of and the challenges to getting appropriate participation. This was a two-fold challenge for the collaborative. First, was the challenge of getting the appropriate organizational members to sustain participation in the collaborative over time. Second, there was the challenge of having the right individuals within those organizations attend meetings and participate in decision-making (discussed more below in the Member Engagement section).

The document review highlights shifting organizational participation over time. Although the kickoff meeting hosted by the mayor included 28 organizational partners, only 25 signed a Letter of Commitment to the project. Conversations highlighted missing partners, so the facilitators reached out to develop relationships. As a result, three organizations came on board over the life of the project. Around 20 of these remained active participants over the life of the project, but only nine organizations remained engaged to the end.

Fluctuation in membership is common in most collaborative work, but a core set of consistent organizational members is critical to the long-term success. A core group of organizational participants with a high degree of commitment allowed the work to continue for three years. One interviewee said “we’ve been on board from day one with the same energy and still see value in trying to create shared work across payers and providers.”

However, the collaborative work was impeded by fluctuations in participation and commitment of the members. One interviewee identified the biggest challenge as “having people move in and out of the collaboration. This kept us from going from theory to operationalization.” Others made similar comments about “not always having consistent membership” and “inconsistent commitment across organizations.”

The shifting membership created challenges with respect to decision-making, as members had varying levels of commitment to the strategic plan as it evolved over time. In some cases, organizational members were hesitant to commit until they could assess whether it would align with their organization, yet they had a voice in shaping decisions through a collaborative design process. Sometimes decisions were guided by the interests of strong or high-profile partners, even if the overall commitment of those partners was tenuous.

It is important to note that some of this movement within the collaborative was necessary to develop the work. A significant shift in participation occurred when the work moved to specific operational details of the project and payment model. The pilot shifted the governance model in an attempt to allow stakeholders with a direct investment in the project to make decisions and allow others to remain in an advisory, non-decision making

role. The result of this shift was that some previously involved members because less active and others became more active.

The interviews highlight that having a core set of organization members was critical to moving the work of the collaborative forward. They also highlighted that progress might have been improved if decision input were tied to demonstrated investment in the collaborative work.

Maintenance: Leadership and Staffing

ARCHI and AHA staff were jointly tasked with managing this project. It was critical that neither organization be perceived as having a separate agenda they were trying to achieve through the collaborative. This "neutrality" was critical at every stage of the project. Over time, the practical day-to-day work of scheduling meetings, drafting agenda, and documenting the work was assumed by ARCHI. Several members noted that ARCHI conducted these processes efficiently. For example, one interviewee said "[All] meetings were helpful – they weren't redundant and there was a sense of momentum." However, others found the leadership team to lack cohesion.

Overall, the feedback reflected that having the leadership team was important for moving the work forward with a sense of momentum, but greater cohesion in this team might have improved momentum.

Maintenance: Structures and Processes

The work of the collaborative was initiated using an inclusive structure. All partners were invited to all appropriate meetings and decision-making processes were inclusive. Over time, certain tasks, such as the development of a payment model and the specifics around intervention implementation, required smaller workgroups in order to make decisions more expeditiously. Once decisions were made within a smaller workgroup they were brought back to the larger collaborative for approval.

Overall, interviewees supported the process put into place and the structure of the workgroups. One participant noted the value of breaking into smaller workgroups to allow groups to focus on narrow tasks, and noted that the larger joint conversations seemed to break down. While there was a general belief that communications were adequate, one respondent noted that earlier distribution of agenda for meetings and announcement of upcoming decisions points might have helped each organization arrange for appropriate participation.

Overall, the processes in place for conducting meetings and the organizational structure of the collaborative work did not appear to be a barrier to moving toward collaborative synergy, despite opportunities identified for small operational improvements.

Maintenance: Member Engagement

Some participating organizations started with and maintained a high degree of engagement over the course of this project. Others struggled to develop leadership buy-in

and long-term engagement with the shared work. Several stakeholders noted the challenges of ensuring that participants have the appropriate levels of authority and expertise when representing an organization to the collaborative. This was noted as a self-reflection ("We struggled to get the right level of leadership and clinical folks on board.") and across organizations ("had each organization sent the proper stakeholder to all meetings, decisions and movement could have happened at a quicker pace," "keeping the right people at the table and engaged would have been helpful," and "about half of the organizations had the right people from the get-go"). Stakeholders observed that member engagement varied across organizations and even within organizations over time, and that this was one of the biggest challenges facing the collaborative. Additionally, interviewees generally credited any success of the collaborative work to the core stakeholders that retained high engagement over time.

Another key point that emerged during the evaluation is that two of the core members that helped drive the work forward were community partners. Home Instead and the Atlanta Regional Commission were invaluable in providing insights on how to engage community-based services in the post-acute phase.

The feedback confirms that a core group of highly engaged participants drove the successes of the collaborative. Collaborative functioning would be improved if each organization continuously evaluates whether the participants in meetings have both the authority and the expertise required to support the collaborative work. This is often an issue for collaborative co-design work: the staff tasked with attending a meeting are often hesitant to bring in senior leadership until the project is more fully formed, but decisions about design and implementation are difficult to define without senior leadership offering their funding support.

Maintenance: Pooled Resources

Five organizations provided funding for coalition formation and maintenance activities; these funds were never intended to fund the implementation of a pilot. The distinction between a planning budget and funds for the value-based payment initiative was not always clear to the stakeholders. One interviewee said the "project had no budget and revenue" and another indicated that they had already put money into the project and were surprised at the expectation that more might be expected of them.

Several partners came to the table with an assumption that the collaborative and its initiatives would be funded by the convening organization or by some of the early participants. Comments such as "there was the assumption that there would be monies that could help with resources and people to provide services…" "[we had] an expectation of financial support to the system" or "I am under the impression that other organizations had more resources already structured in place to assist in success" show the high degree of variability across the membership with respect to understanding their role in supporting this project with resources.

Stakeholder interviews led evaluators to conclude that the pooled resources that were available to support the formation and maintenance phase of the collaborative work were critical to the successes achieved. Communication with members about the difference

between funding to support planning and a budget for the value-based purchasing initiatives was a challenge.

Additionally, this pilot was billed as a value-based project, which means that many stakeholders brought a transactional mindset to the work. This focus on a payment being tied to a direct ROI for a particular subset of CHF patients was difficult to navigate. The value proposition for this multisystem, multipayer pilot was around shared learnings that would benefit CHF patients, and that learning could be maximized by providing the intervention regardless of insurance coverage. That value proposition led some entities to see the initial pilot work as fundable through their foundations or other avenues while other entities were without a funding mechanism. This learning was important but made it difficult for payers to find unrestricted resources within their organizations upon which to draw.

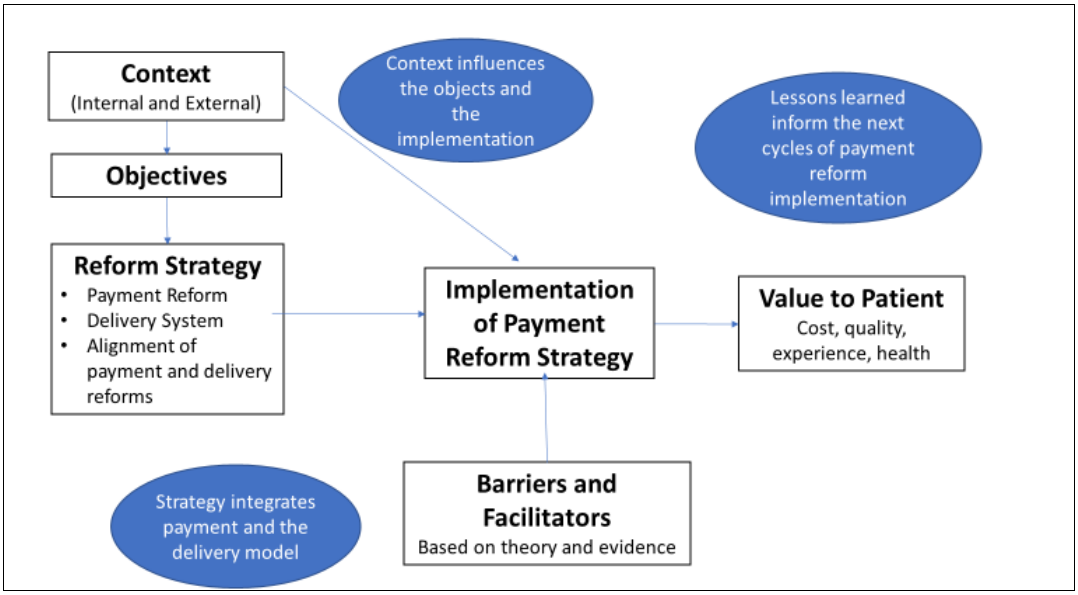
Maintenance: Future of the Collaborative

Although the collaborative did not implement a value-based payment program that was multipayer and multiprovider, there is interest in maintaining the collaborative structure for future work. The COVID-19 crisis has created a desire for a venue to share conversations about payment reform, COVID recovery, and disparities in COVID impact. Stakeholders felt that they built an infrastructure that can respond to other collaborative work. They also felt that this was their only opportunity to meet across organizations to work together in different ways and wanted to be able to continue that in some form.

Evaluation of the Work around Value-based Health Care

The WEF defines value-based health care as “an approach that aligns industry stakeholders around the shared objective of improving health outcomes delivered to patients at a given cost, and then to give stakeholders the autonomy, the right tools and the accountability to pursue the most rational ways of delivering value to patients” (WEF, 2020). The section below provides a summary of the evaluation of the value-based care model the collaborative pursued. This work relies on a model by Conrad, Vaughan, Grembowski, & Marcus-Smith (2016) that “describes how context, project objectives, payment and care delivery strategies, and the barriers and facilitators to translating strategy into implementation affect value-based payment implementation and value for patients.”

Figure 2: Value-Based Payment Reform Conceptual Framework



Conrad et al. 2016.

This model is helpful for evaluating this particular project because it is not specific to any particular form of value-based payment and encompasses the need to consider payment and delivery system reform.

Objectives

The partners convened around the purpose of addressing "value-based care" for CHF in Atlanta and then were tasked with defining specific objectives to be pursued around that purpose. When reviewing the literature and white papers about value-based care, including documents from collaborative partners, a wide range of definitions for value-based care were identified. Consistent with the literature (Minemyer, 2019), achieving consensus regarding the definitions of value-based care is a challenge. While stakeholders agreed that value depends upon the relationship between care outcomes and cost, there are differing perspectives on how and over what time care outcomes should be measured. Some of the definitions that this collaborative struggled with were the timeframe for reducing the cost of care, the window for readmissions, and palliative care. These differences in definitions translated to challenges in establishing objectives. This was noted by several stakeholders, one of whom commented that a "value-based model has differing incentives for each stakeholder."

Despite these challenges, the collaborative formed consensus around focusing on the SDOH because of the role these play in post-acute care and quality outcomes and because no system or payer felt it was adequately addressing SDOH issues with their CHF patients. Additionally, the collaborative formed consensus on using a reduction of readmission rates as a measure of those outcomes. While this was adopted by the collaborative as a whole, the stakeholder interviews revealed some tension around this focus. For example, one

mentioned the desire to see a definition of success that incorporated “improved quality of life.”

The collaborative specifically chose to focus on community-based, nonmedical care because the members believed it would “provide some early wins.” In addition, partners defined several intermediate goals around common data collection efforts, development of a community resource guide, and implementation of a minipilot between one of the participating health systems and a home-health care provider focused on improving access to social supports.

Despite coalition adoption, not all partners agreed that these intermediate goals represented success metrics. One stakeholder noted “data was not a success metric. No one will agree on datasets until there is a true health information exchange.” Another preferred a focus less on data elements and believed that the agreed upon dataset was cumbersome.

Overall, stakeholders felt that the work of the collaborative to narrow its focus and identify intermediate objectives was critical to keeping partners engaged with the work. However, despite an inclusive process designed to reach agreement around the objectives, not all partners embraced the objectives as they were defined.

Reform Strategy: Payment Reform

The collaborative agreed in principle on a value-based payment design focused on pay-for-performance. Payment would be based on a reduction in readmissions after discharge, achieved through an evidence-based model (the Coleman Model) to address the SDOH. Over time, the collaborative also achieved success in defining the target population for inclusion in the patient pool through a detailed decision tree that would clearly determine which patients were included in the pilot. However, while this overarching agreement was achieved, several contentious issues surfaced and the participants in the collaborative could not achieve consensus.

1. Despite the adoption of the evidence-based model, some participants wanted the collaborative to drive innovation around interventions to reduce readmissions. Interviews substantiated this dichotomy with comments simultaneously supporting the need for “evidence-based intervention” and a “play book of algorithms” and other responses highlighting the “opportunity to learn new things” and a desire to “be more innovative.” The expected fidelity to the Coleman Model was not clear.

2. The distribution of risk was not universally and clearly agreed to across collaborative partners. Payers anticipated funding a pool that would only make payments for success, while providers sought some certainty that payments would cover at least some of the costs for implementation.

3. Early discussions about the potential level of funding for the pilot proved to be unrealistic for the payers. As the potential funding levels declined, the pilot was downsized and the concerns about payment methodology grew. There was not

clear agreement on whether payments would be made on a per patient basis for those who did not readmit or based on a reduction in readmission rates for each provider. Providers' concern about using rates to determine payments grew as the patient pool shrank.

4. In addition, payers struggled with the notion of funding a pay-for-performance pool with payments linked to patients whose care was covered by other payers not participating in the collaborative, most notably public plans (Medicare and Medicaid).

Although the collaborative moved toward some consensus around a pay-for-performance model and the population most at risk, the details of the payment model were not sufficiently resolved to allow for implementation. Additionally, this area of work highlighted the difficulty of navigating the tension between innovation and evidence-based initiatives in a risk-based environment.

Reform Strategy: Delivery System Reform

Interviews confirm that most collaborative partners recognize the need to form partnerships with external organizations to address the post-acute care needs of the target population. The catalogue of available community supports that was developed as part of this project is generally viewed by the partners as an accomplishment. The collaborative members increasingly recognize the expansive role for partnerships with community-based organizations to address the SDOH, and several stakeholders mentioned that this project has increased the likelihood of collecting information about SDOH and addressing patient needs through new partnerships across their patient populations.

Barriers and Facilitators

Many of the facilitators necessary to support multistakeholder implementation of value-based payment reform noted by Conrad, et al. (2016) were cited as in place by the collaborative stakeholders. For example, as noted above, the stakeholders generally found the leadership of the collaborative to be effective and noted the favorable political environment (mayoral support) and the strength of the convener (WEF) to be facilitators of the collaborative achievements.

However, the stakeholders identified several barriers to successful implementation of payment reform, some of which have been addressed above as they relate to the collaborative itself. With respect to implementation, there was a strong theme among respondents about differential perceptions of and willingness to bear risk. For example, one stakeholder cited the lack of "alignment around how risk would be shared." Several noted that payment incentives were not clear in advance or that their organization was struggling to commit resources without a clear benefit to their own patient population. One stakeholder cited risk of 'double payments' given the existing transactional relationship between organizations.

When considering all of the responses and activities, the evaluation found organizations invested significant levels of human capital to plan a value-based payment reform pilot,

but there were organizational barriers to putting cash resources at risk with uncertain ROI and the potential to benefit enrollees (for the payers) or patients (for the providers) served by competing organizations.

A second theme that emerged from conversations about barriers to success was around data collection and sharing. Despite the collaborative approval of the ICHOMS dataset as the basis for this work, the provider organizations were not unanimous in their willingness or ability to build the necessary data collection tools into their EMRs and to share those data consistently across organizations for CHF patients. One stakeholder mentioned that the ICHOMS dataset was 'cumbersome' and another linked the value of data collection to full implementation of a health information exchange.

In general, stakeholders noted several facilitators that supported this work, but the inability to get to implementation appears to be driven by barriers related to financial risk and lack of consensus around the data.

Additionally, it is important to note that there were a number of external factors that influenced the work of the VBHC HF Collaborative. First, the prevalence of and energy around value-based payments changed significantly across the life of the project. The Georgia Department of Health and Human Services had a great deal of energy around this in 2017 when the pilot started, but that since shifted, influencing the local provider incentives for participation. Second, Atlanta elected a new mayor who was inaugurated in 2018. While the incoming (and current) mayor expressed interest and support for the pilot, it is not a priority for her office. Lastly, Kaiser Permanente—a major partner and funder in the work—shifted their hospital admissions to Emory Healthcare. Emory has been unable to move forward with the necessary data builds to facilitate the work, which would essentially disqualify Kaiser Permanente patients from the pilot.

ACCOMPLISHMENTS

Although the coalition did not achieve implementation, stakeholders identified a number of accomplishments. The accomplishments fit within these general themes:

- Identifying and cataloging of social support resources that continues to benefit their organizations beyond the pilot project
- Building relationships and developing new health partnerships
- Participating in thoughtful conversations around a common goal and the sharing of ideas and best practices for CHF patients
- Focusing on the SDOH and the impact of social supports on clinical outcomes that is shaping care across other areas of their organization
- Sustaining the coalition as a potential vehicle for other work.

LESSONS LEARNED AND STRATEGIES/ RECOMMENDATIONS FOR FUTURE WORK

There are a number of lessons learned about the challenges encountered in this project. Below are strategies and recommendations for future collaborative work around value-based payments.

Challenge: Initial excitement and high levels of participation do not necessarily translate to the correct configuration of organizations to actually do the work. Despite early consensus on the shared work, the need to continuously assess membership delayed implementation.

> *Recommendation:* Future work would benefit from initiating strategic conversations with stakeholders around who is not represented and conducting mapping exercises to identify gaps in representation.

Challenge: There was considerable fluctuation in commitment and engagement of coalition members and support staff over time. Some had decision-makers at the table, others did not. This fluctuation in commitment and staff meant that the cadence of the work slowed down.

> *Recommendation:* To the extent possible, collaborations should seek to develop a core group of participants. To expedite the process of collaboration in the future, it will be important to ensure that the people at the table are able to make decisions. Collaborative functioning would be improved if each organization continuously evaluates whether the participants in meetings have both the authority and the expertise required to support the collaborative work. Coalition staff may want to devote time to evaluating the best participants from various organizations for each meeting.

Challenge: Several governance structures were attempted to find one that would allow the organizations that have a vested interest in the work (financial or patients) to make decisions quickly while keeping noninvested organizations in the loop.

> *Recommendation:* In order to expedite this process in the future, it will be important to determine an effective structure early on in the process. Because value-based models involve risk sharing it is important that these structures appropriately align decision-making with those who will ultimately bear the risk.

Challenge: Inclusive decision-making processes can easily be driven by vocal or highly visible potential partners, even before these partners have made a firm commitment to the project. Over time, as membership and commitment evolve, early decisions may no longer reflect the consensus of those remaining in the coalition.

> *Recommendation:* It may be possible to link voting rights to demonstrated commitment to the work of the coalition. This may be especially true of there are a large number of participants with limited willingness or ability to commit resources.

Challenge: Collaboration between competing entities is not easy. Much of the work that payers bring to the table is considered proprietary and sharing that information is uncomfortable and often prohibited. Providers, similarly, are guarded when it comes to sharing patient care guidelines and outcomes data.

> *Strategy*: Shuttle diplomacy was used to address this issue, with payers and providers meeting separately to outline what was important to them and then sending the other party feedback. This structure and ARCHI staff roles allowed movement toward agreement on the payment model. It also allowed providers and payers to freely explore and express what they needed to "get" out of the process which sped up the work. However, it did not allow the collaborative to overcome perceptions of skewed risk and the reality of not having a mechanism for providing value-based payments for noncovered populations. In the end this was a collaboration, but it was a collaboration among competitors (health systems compete with one another and payers compete among one another) and a collaborative among partners that normally negotiate to extract value from one another (payers negotiate prices with health systems on regular cycles so sharing data that would give either party an advantage in future negotiations was difficult).

Challenge: The collaborative attempted to disrupt "business as usual." This created discomfort in a number of areas, such as moving away from a "fee-for-service' structure toward value-based payments that benefited population health, circumventing proprietary restrictions on data-sharing, and working around current payer-provider contracts that already addressed some value-based work.

> *Strategy:* The collaborative attempted to work around these issues by aggregating any data that was shared without linking it to any one payer or provider, focusing on interventions that would not interfere with existing contracts, and continually illuminating the innovation of this type of work. Most meetings started with a reminder about the shared value that the collaborative was working toward and agreements that had already been reached.

Challenge: Pooled funding that benefits all patients in the pilot, regardless of payer and coverage, is hard to implement. Payer funds from premiums are often restricted as to use and do not lend naturally to funding population health initiatives. Payers also need some assurance that their patient populations will benefit.

> *Recommendation:* In order to move forward population-based initiatives, future multistakeholder collaboratives will need to seek out foundation or community benefit funding available within payers or seek outside funding for the pilot. Funding from premium revenue depends upon the ROI for each payer.

Challenge: Medicare and Medicaid are the largest payers in the local health system. Medicare is a major payer for CHF patients and penalties for readmissions are a strong driver in providing care for these patients. Not having Medicare representation in the collaborative was a large roadblock to implementation.

Recommendation: Develop a payment model that is complementary to Medicare's payment structure, and recognize the importance of the Medicare and Medicaid populations to the pilot. If possible, include public payer representation in the multipayer collaborative.

Challenge: Payers and providers have existing value-based contracts. In working on this pilot, both payers and providers tended to revert to their existing models and contracts for value-based care, even if these models were not specific to CHF or standardized across hospital systems.

Recommendation: This collaborative might have gained traction in this area by leveraging Medicare-initiated value-based programs or building on existing value-based work that is already being done at the payer or provider level.

Challenge: Despite consensus on an ideal dataset, the costs of building the tools for collection were deemed prohibitive by some partners. The collaborative initially decided on a minimum dataset but then adopted the ICHOMS dataset, as it provided additional details around the social support services that health systems were eager to adopt. The ability to adopt the ICHOMS dataset varied greatly across the collaborative, as some hospital systems have more flexibility with their EMRs than others and adding or altering data fields is an easier lift. The coalition was never able to resolve this problem in a way that led to at least some data collection and sharing.

Recommendation: The desire to adopt the ICHOMS dataset was built on a real desire to address the needs of CHF patients but there was not agreement on the timeline and resources for the EMR build-outs. The collaborative would have been better served by starting with data that was being collected across health systems as a minimum dataset, then building additional agreed-upon data fields as possible.

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APPENDIX 1: COLLABORATION PARTNERS

List of Organizations That Signed a Letter of Commitment for Participation in the Atlanta VBHC HF Collaborative

Alliant Quality
American Heart Association
Atlanta Regional Collaborative for Health Improvement
Atlanta Regional Commission
Blue Cross Blue Shield (now Anthem Blue Cross)
Boston Consulting Group
Centene Corporation
City of Atlanta Mayor's Office
Dekalb County
Emory Healthcare
Georgia Department of Public Health
Georgia Health Information Network
Grady Health System
Home Instead, Inc.
Humana, Inc.
Kaiser Permanente
Medtronic
Morehouse School of Medicine
Myia Health
Northside Hospital
Novartis
Philips
Piedmont Healthcare
Qualcomm Life
UnitedHealthcare
Wellstar Health System
Welltower, Inc.
World Economic Forum

List of Additional Organizations Engaged Over the Course of the Pilot

Aetna
Centers for Medicare & Medicaid Services
WellCare

APPENDIX 2: EVOLUTION OF THE COLLABORATIVE, 2017-2020

September 2017
Stakeholders Asked to Participate

Alliant Quality, American Heart Association, Atlanta Regional Commision, ARCHI, Blue Cross Blue Shield (now Anthem Blue Cross), Boston Consulting Group, Centene Corporation, City of Atlanta Mayor's Office, Dekalb County, Emory Healthcare, Georgia Department of Public Health, Georgia Health Information Network, Grady Health System, Home Instead, Inc, Humana, Kaiser Permanente, MYIA Health, Medtronic, Morehouse School of Medicine, Northside Hospital, Novartis, Philips, Piedmont Healthcare, Qualcomm Life, UnitedHealthcare, Wellstar Health System, Welltower, Inc, World Economic Forum

November 2017
Stakeholders Commited (LOC) to the VBHC Pilot

Alliant Quality, American Heart Association, Atlanta Regional Commision, ARCHI, Blue Cross Blue Shield (now Anthem Blue Cross), Boston Consulting Group, Centene Corporation, City of Atlanta, Dekalb County, Emory Healthcare, Georgia Department of Public Health, Georgia Health Information Network, Grady Health System, Home Instead, Inc, Humana, Inc., Kaiser Permanente, MYIA Health, Medtronic, Moorehouse of Medicine, Novartis, Philips, Piedmont Healthcare, Qualcomm Life, UnitedHealthcare, Wellstar Health System, Welltower, Inc., World Economic Forum.

February 2018
Defining Stakeholders Roles within the Project, Smaller Workgroups, Dataset

American Heart Association, Atlanta Regional Commision, ARCHI, Blue Cross Blue Shield (now Anthem Blue Cross), Boston Consulting Group, Centene Corporation, City of Atlanta Mayor's Office, Dekalb County, Emory Healthcare, Georgia Department of Public Health, Georgia Health Information Network, Grady Health System, Home Instead, Inc, Humana, Kaiser Permanente, Medtronic, Morehouse School of Medicine, Novartis, Philips, Piedmont Healthcare, Qualcomm Life, UnitedHealthcare, Wellstar Health System, World Economic Forum

October 2018
Change in Meeting Structure – Separate Payer and Provider Workgroups

American Heart Association, Atlanta Regional Commision, ARCHI, Blue Cross Blue Shield (now Anthem Blue), Boston Consulting Group, Centene Corporation, City of Atlanta Mayor's Office, Dekalb County, Emory Healthcare, Georgia Department of Public Health, Georgia Health Information Network, Grady Health System, Home Instead, Inc., Humana, Inc., Kaiser Permanente, Medtronic, Morehouse School of Medicine, Novartis, Philips, Piedmont Healthcare, Qualcomm Life, UnitedHealthcare, Wellstar Health System, World Economic Forum

January 2019
Separate Payer and Provider Workgroups

American Heart Association, Atlanta Regional Commision, ARCHI, Blue Cross Blue Shield (now Anthem Blue Cross), Centene Corporation, City of Atlanta Mayor's Office, Emory Healthcare, Georgia Department of Public Health, Georgia Health Information Network, Grady Health System, Home Instead, Inc., Humana, Inc., Kaiser Permanente, Medtronic, Novartis, Philips, Piedmont Healthcare, Qualcomm Life, UnitedHealthcare, Wellstar Health System, World Economic Forum

April 2019
Separate Payer and Provider Workgroups

Aetna, American Heart Association, Blue Cross Blue Shield (now Anthem Blue Cross), Atlanta Regional Commission, ARCHI, Centene Corporation, City of Atlanta Mayor's Office, Emory Healthcare, Georgia Health Information Network, Grady Health System, Home Instead, Inc., Humana, Inc., Kaiser Permenante, Peidmont Healthcare, WellCare, Wellstar Health System, World Economic Forum

October 2019
Determining Stakeholder Engagement/ Updated Commitments - Joint Meeting

American Heart Association, Blue Cross Blue Shield (now Anthem Blue Cross), Atlanta Regional Commission, ARCHI, Centene Corporation, Emory Healthcare, Grady Health System, Home Instead, Inc., Humana, Inc., Kaiser Permenante, Peidmont Healthcare, WellCare, Wellstar Health System

January 2020
Stakeholder Engagement - Post Joint Meeting

Blue Cross Blue Shield (now Anthem Blue Cross), Emory Healthcare, Grady Health System, Humana, Inc., Kaiser Permanente, Piedmont Healthcare, Wellstar Health System, WellCare, United Healthcare

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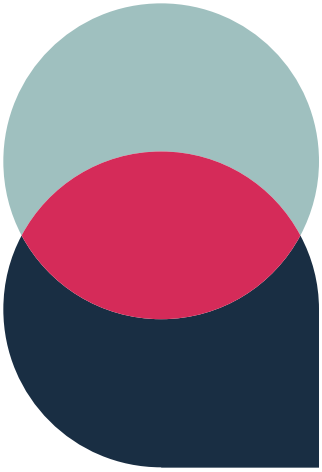

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