

## **Part 5: The Challenge of Evaluating Payment Reform Grant Projects**

*Authors: Barbara Leonard, MeHAF's Vice President for Programs with Jeanine Limone Draut, InPraxis Communications*

Our experience with payment reform grants helped to change our way of thinking about grantmaking and evaluation because of the innovative and complex nature of projects that experiment with options for health reform.

Fourteen organizations were funded to work on projects focused on mitigating the increasing cost of health care through innovative payment reform strategies, ensuring that people who are uninsured and medically underserved are included in these efforts. The goal was to fund projects that would preserve access, improve quality, and offer better value for our health care spending. MeHAF awarded nearly \$3 million in three rounds of three-year grants to support this work during 2011-2014, and awarded several of the first round grantees an additional two-year grant of \$75,000.

In a series of interviews with grantees we conducted in late 2014, grantees shared the stories of their journey from the beginning of their funding to the conclusion of their work. Nearly every grantee found that their journey took them in a different direction than they anticipated. This posed a challenge to the structured evaluation process we had planned.

### **Manage the tension between big Ideas and incremental change**

Several grantees (in separate interviews) used the phrase “building the airplane while we fly it” to capture the risk and technical difficulty of these projects. We’d like to take that metaphor one step farther.

Imagine that you are asked to turn an airplane into a rocket. But here’s the catch: you have to keep the airplane flying and functional while you do it because there are a lot of people on the plane, and their lives depend on it.

That’s the difficulty with payment reform. We are in desperate need of innovation in the way we pay for health care so we can see better results for the health care dollars spent. These new approaches have the potential to transform the system, yet must be done with a careful stepwise approach. They must be bold, yet not completely disrupt the system.

### **Use developmental evaluation**

Though we started our grant with a traditional evaluation plan and process, we came to understand that the complexity of payment reform and the dynamic environment in which health care innovations percolate make these projects better suited to an adaptive, developmental evaluation.

Michael Quinn Patton described this type of evaluation, which is characterized by rapid learning rather than accountability for specific results, and grantee involvement in evaluation rather than outside objectivity. It measures adherence to values and big goals rather than delivery of expected outcomes. It is more about adaptation than rigorous follow-through.

### **Allow projects to have “peripheral vision” and be responsive**

It is often said that when it comes to innovation, it’s good to “fail fast” so we can stop spending time and money on it. But in the uncertain and fluctuating world of health care payment reform,

an apparent “failure” may simply mean that the timing isn’t right or the intervention was based on something that was once true but no longer is. It’s important for funders to create the safety to explore these road blocks and wrong turns.

Frank Johnson of the Maine Health Management Coalition expressed his gratitude that grantees could “have the candor to be able to acknowledge where there have been some real obstacles and where assumptions didn’t develop as they anticipated, and they had to re-try.”  
<https://vimeo.com/135067363>.

Several projects had to adjust when their initial assumptions proved to be wrong. Two projects designed to reduce charity care costs at Franklin Memorial Hospital and Mercy Health System changed approaches for two reasons: national health care reform changed the landscape, and leaders of each project, Tracy Harty and Melissa Skahan, learned that their initial assumptions about how and why people were using charity care were wrong. As Tracy noted about her work at Franklin Memorial, “when we first got started I was under the impression that we would find a population, and very quickly we would determine what was wrong with them, and there would be a few categories ... But as it turned out ... [the problems are] really all over the place.”  
<https://vimeo.com/135067365>.

Similarly, Linda Foley and the rest of the team at Aroostook Medical Center found that their assumptions about what was driving emergency room use were wrong. They had assumed that those who were overusing the emergency room either had no insurance or were not very good at navigating the health care system. Instead, they found that insurance was not a main driver, and that the patients in the emergency room were, in fact, very involved in managing their health care. Said Linda, “We had to reorient our goal and how to achieve it.”  
<https://vimeo.com/135067364>.

### **Allow projects to build infrastructure and catalyze system change**

With payment reform, we are changing the whole approach to delivering and paying for health care, from one that pays for volume of services to one that pays for the wise, patient-centered use of services. This requires new infrastructure, such as common data sources and new additions to the traditional doctor-nurse care team. In our evaluation of payment reform projects, we realized that we would not be able to answer the question, “Did it save money?” within the timeframe of the projects. But we have tried to capture the value of the investments grantees are making on infrastructure.

Several funded projects initially focused on implementing accountable care models but transitioned to building the infrastructure necessary for accountable care approaches to work. One project led by Stephanie Peters from MaineHealth evolved to become an effort to strengthen primary care when she realized that this basic building block of accountable care could not support system change in its current state. <https://vimeo.com/135067362>.

Another project that was originally focused on accountable care implementation evolved to focus on developing common measurements used for contracting and payment purposes in accountable care. While this focus on measures may seem “micro” relative to the major system changes that are sought through payment reform, the organizations working with the Maine Health Management Coalition noted that different quality measures for different payers was a significant barrier to change.

An important but often overlooked aspect of infrastructure is new connections and relationships in the system. Our grantees' work is forging new collaborations not only within health care but among payers, health care workers, and social service workers. These new connections are an essential first step toward doing health care in new ways. For example, patient-centered medical homes with community care teams may cost more in the short run. But in the process of putting these teams in place, Maine Quality Counts is building will, trust, relationships and infrastructure to allow professionals of different disciplines to work together for better care.

As Lisa Letourneau from Maine Quality Counts has said, payment reform projects are a “catalyst for change.” Instead of focusing narrowly on specific outcomes, our evaluation of payment reform projects has attempted to capture the changes our grantees have set into motion in the chaotic and evolving context of health care.

*Developed with assistance from Andrea Gerstenberger, Grantwise Consulting and Holly Merrithew, MeHAF*