2018

Delivery System Reform Incentive Payment (DSRIP) Program

Independent Evaluation
Annual Performing Provider System (PPS) Report for **North Country Initiative PPS**

DSRIP Demonstration Year 0 – DSRIP Year 3

Prepared by: Paloma Luisi, MPH; Sarah Rain; Rose Greene; M.S.; Margaret Gullick, Ph.D.; Amanda Rozsavolgyi, M.S.Ed.; Mandi Breen, M.A.

Center for Human Services Research

University at Albany

NEW YORK STATE | Department of Health

CENTER FOR HUMAN SERVICES RESEARCH
UNIVERSITY AT ALBANY State University of New York

Overview of Report

The objective of this report is to share interim results of the Delivery System Reform Incentive Payment (DSRIP) program evaluation with the Performing Provider Systems (PPS) to inform implementation efforts. This report is focused on the Samaritan Medical Center PPS (also known as North Country Initiative or NCI). Assessments of the implementation, operation, and patient care as shared by the study participants of this PPS will be reflected in this report. These findings will be supported by representative quotations and descriptive statistics.

As the Independent Evaluator (IE) launched data collection in 2017, this 2018 report will serve as a lookback for DSRIP Demonstration Year 0 through half of Year 3 for this and each PPS. This is considered the IE's Research Cycle 1 which will be followed by reports for Research Cycle 2 and then a final Research Cycle 3, in 2019 and 2020 respectively. Data sources for this 2018 report include PPS key informant interviews, partner surveys of health care providers, and surveys of patients.

The report is organized into the following sections:

Section I. Background Information

1. Background and Statewide Evaluation Approach
2. Description of Methods and Data Sources for this PPS Annual Report

Section II. North Country Initiative PPS

3. North Country Initiative PPS Brief Overview
4. North Country Initiative PPS Findings
5. Recommendations for North Country Initiative PPS
6. Conclusion and plans for future research

Section I.
Background Information

1. BACKGROUND AND STATEWIDE EVALUATION APPROACH

1.a DSRIP and PPS background

The New York State (NYS) DSRIP program is a reinvestment of $6.42 billion of federal savings generated by Medicaid Redesign Team (MRT) reforms. The five-year program is intended to bring about comprehensive system transformation through community-level collaboration and implementation of innovative projects. To implement these changes, 25 Performing Provider Systems (PPS) were formed as partnerships between hospitals, other health care providers, and community-based organizations. Each PPS chose specific projects to best meet their communities' needs. A PPS is composed of regionally collaborating providers who will implement the projects. DSRIP payments to these PPS are based on performance measures, including reductions in avoidable hospitalizations, clinical care improvements, and population health improvements. The responsibilities of each PPS include:

- Conducting a community health care needs assessment based on multi-stakeholder input and objective data;
- Implementing a DSRIP project plan based on the needs assessment in alignment with DSRIP strategies; and
- Meeting and reporting on DSRIP project plan process and outcome milestones.

1.b Independent evaluation approach

The Research Foundation of the State University of New York at the University at Albany is conducting a statewide evaluation of the DSRIP program. The evaluation employs quantitative and qualitative methods to achieve the following goals:

- To assess program effectiveness on a statewide level with respect to the Medicaid Redesign Team (MRT) Triple Aim of improving care, improving health and reducing per capita costs;
- To obtain information on the effectiveness of specific projects and strategies selected by the PPS and the factors associated with program success; and
- To obtain feedback from stakeholders, including NYS Department of Health (DOH) staff, PPS administrators and providers, and Medicaid beneficiaries served under DSRIP regarding the planning and implementation of the DSRIP program, and on the health care service experience under DSRIP reforms.

The Independent Evaluator is using a mixed methods strategy to meet the project objectives. Mixed methods approaches offset the weaknesses inherent in single method approaches, and allow evaluators to confirm, cross-validate, and corroborate the findings (Creswell, et al., 2003; Teddlie and Yu, 2007). In the final stage of the analysis, findings from the different analyses and sources will be triangulated to develop an integrated analysis.

The evaluation consists of three components: (1) an implementation and process evaluation, (2) a time series evaluation; and (3) a comparative analysis. Each evaluation component is summarized below.

1.b.i Implementation and process evaluation

The implementation and process evaluation provides context regarding the health care infrastructure existing prior to DSRIP, process factors (e.g., communication, leadership) that shaped each PPS, and program implementation strategies utilized by each PPS. Data sources include:

- Focus groups with DSRIP-engaged partners conducted annually in different regions of the state
- Semi-structured key informant interviews with PPS senior leadership and PPS project administrators
- Electronic surveys of DSRIP-engaged partners (Partner Survey)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys of patients

Further detail on these methods is provided in the "Description of Methods and Data Sources for this Report" section below.

1.b.ii Time series evaluation

The statewide impact of DSRIP is being evaluated using an interrupted time series design with segmented regression. This component of the project looks at health care service delivery, health improvements, and cost to the Medicaid program at the state level during the study period. It also includes an inter-PPS analysis to identify components that posed successes or challenges for implementation and outcomes, through difference-in-differences analysis. Data sources for the time series evaluation are:

- Medicaid claims
- Medicare claims
- Statewide Planning and Research Cooperative System (SPARCS) data
- New York State Vital Statistics
- The Minimum Data Set (MDS) of nursing home residents
- Patient surveys (CAHPS)

1.b.iii. Comparative analysis

The comparative analysis applies quantitative techniques to assess relative PPS performance on domain-specific metrics over time. This work will be supplemented by qualitative data emanating from the implementation study to further contextualize the findings. Methods will include the development of clusters of PPS to serve as comparison groups according to project selections, difference-in-differences analysis, and multi-level modeling.

2. DESCRIPTION OF METHODS AND DATA SOURCES FOR THE PPS ANNUAL REPORT

The table below summarizes the data sources in the PPS-specific reports. The last row shows the final sample sizes for North Country Initiative PPS. Following the table are further details about the methods used to collect these data.

	PPS Key Informant Interviews	Statewide Partner Survey	Patient Survey (CAHPS)	Partner Focus Groups
What	Semi-structured telephone interviews conducted to collect information on PPS organizational development and perceived performance.	Web-based survey of project-associated partners to collect information on the functioning of individual projects.	Mail and phone survey of Medicaid members to collect information on patient perspectives of health care providers.	In-person focus groups of project-associated partners to collect information on their perceptions of the DSRIP program.
Who	PPS administrators and staff at each of the 25 PPS who were most knowledgeable about DSRIP start-up, implementation, administrative components, and challenges in Demonstration Years 0-3.	Partners engaged in PPS projects.	Medicaid members ages 18-64 who were attributed to one of the 25 PPS and had at least one visit with a primary care or obstetrics/ gynecology provider in the PPS network.	Partners engaged in PPS projects from the Capital District and Adirondack regions.
When	July – August 2017	September – November 2017	Demonstration Year 1: September 2015 – December 2015 Demonstration Year 2: September 2016 – November 2016	November 2017
Final Sample Size at NCI	**4**	**35 (response rate of 45%)**	**Demonstration Year 1: 532 (response rate of 38%)** **Demonstration Year 2: 363 (response rate of 34%)**	**n/a**

2.a Key informant interviews

From July through August 2017, interviews were conducted with PPS administrators and staff. Using purposive sampling (Bryman 2012; Creswell 2013; Patton, 2002), the evaluation team identified administrators at each of the 25 PPS who were most knowledgeable about DSRIP start-up, implementation, ongoing processes, administrative components, and challenges in the first two DSRIP years. If a single person did not possess the necessary knowledge and background in each of these areas, additional people were included in the interview. Generally, the sample included one or more of the following individuals:

- Chief Executive Officer
- Chief Operating Officer, or the individual currently responsible for all operations
- Someone with authority who was involved in PPS startup
- Fiscal officer or individual involved in financial transactions
- Others identified by either the NYS DOH or the PPS who were vital to the ongoing operations of the PPS

The interviews were guided by an interview protocol that was designed to address the following topics:

- Initial formation of the PPS
- Early operations
- Administrative issues and structural configurations
- Challenges and successes
- Perceived outcomes and recommendations

Development of the interview guide included identification of major topics that were within the scope of the research questions of the implementation and process study. The final guide included questions approved by the NYS DOH. Furthermore, the interview guide was tailored to individual roles and PPS organizations once participants were identified. For example, some PPS had legacy staff who were with the project since initial formation and other PPS experienced full turnover. As such, questions were developed to be flexible within the knowledge scope of interview participants. Publicly available documents such as the Mid-Point Assessment Reports were also reviewed to provide background information to help guide each interview. The interviews were conducted by the same two qualitative researchers for reliability. Notes were taken concurrently to the telephone interview and then one researcher listened to the tape to produce the final transcript. Finally, the interviews were organized into major themes and coded.

Interviews were conducted with four key informants from North Country Initiative PPS. To ensure confidentiality for participants in these interviews, only general findings that were supported by the Partner Survey are provided in this report.

See Appendix I for the Key Informant Interview Guide: Research Cycle 1.

2.b Partner Survey

To gather uniform information on the functioning of individual projects, an electronic survey was administered to project-associated providers. To identify respondents, the evaluation team built unique contact lists of providers for each of the 25 PPS using provider network lists from the Provider Export/Import Tool (PIT) with corresponding contact information from the Medicaid Analytics Performance Portal (MAPP). The contact lists were sent to the PPS for review and to identify "engaged providers" who were contractually involved in PPS projects. Engaged providers were defined as providers or organizations that were participating in one or more of the PPS's projects. As this survey was focused on agencies involved with a DSRIP project, rather than all partners who provide services, the sample was defined narrowly. A PPS may have many more partner agencies or individual practitioners than were included in the survey sample. The survey questions covered the following topics:

- Service provision and project operations
- Factors that helped or hindered their implementation

- Level of satisfaction with project operation
- Reflections on what worked well and less well
- The overall perception of DSRIP
- The overall perception of projects

The survey launched in September 2017 on the Qualtrics online survey platform and closed in November 2017. For this report, Partner Survey data were cleaned by the evaluation team and then analyzed using SPSS for respondent characteristics and respondent perceptions of project evaluations, DSRIP benefits, benefits by project type and organization type, value based payment, and DSRIP effectiveness.

In North Country Initiative PPS, the survey was sent to 78 e-mail addresses and 35 responses were received, generating an estimated 45% response rate. Please note that because the survey was sometimes forwarded to additional people, it is not possible to calculate the exact response rate.

Quantitative and qualitative results from the Partner Survey are included in this report. Quotes received from participants engaged in the Independent Evaluator's summer and fall 2017 research activities were minimally edited for clarity, but not for grammar.

See Appendices II and III for further details about Partner Survey methodology and a copy of the instrument.

2.c. Patient survey (CAHPS survey)

Patient perspectives were assessed via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, administered annually by Datastat, Inc. The survey included the CAHPS C&G Adult Medicaid core survey (Primary Care, version 3.0), a nationally vetted tool designed to assess the performance of clinicians and medical groups, with items addressing many domains of patient experience, such as receipt of timely care, communication with doctors, and overall satisfaction with their provider. In addition, the survey included 18 supplemental questions of particular interest to NYS DOH concerning health literacy, health promotion, and care coordination.

The surveys were administered to a sample of Medicaid members, aged 18 to 64, who were attributed to a PPS and had at least one visit with a primary care or OB/GYN provider in the PPS network. Each year's survey included 1,500 adults from each of the 25 PPS in New York. Surveys were sent to 37,500 members following a combined mail and phone methodology (three mailings, followed by phone follow-up of non-responders).

The CAHPS data presented in this report were collected in Demonstration Years 1 and 2 (DY1 and DY2), providing insight into the early implementation of DSRIP. The DY1 survey was conducted between September 14, 2015 and December 7, 2015. In North Country Initiative PPS, a total of 532 responses were received resulting in a 38% response rate (after excluding ineligible participants). The DY2 survey was conducted between September 16, 2016 and November 30, 2016. A total of 363 responses were received in DY2, resulting in a 34% response rate. As of the writing of this report, the CAHPS data collected in the fall of 2017 for Demonstration Year 3 were not yet finalized.

2.d Focus Groups

Partner focus groups were not conducted in Research Cycle 1 in this PPS region. Focus groups will be conducted in Research Cycle 3 in this area.

Section II.
North Country Initiative PPS

3. NORTH COUNTRY INITIATIVE PPS BRIEF OVERVIEW

3.a PPS information

Attribution is the process by which a Medicaid member is assigned to a Performing Provider System. The attribution methodology applies a utilization algorithm to a hierarchical category of provider types. The algorithm's purpose is to attribute for significant "loyalty" relationship in the provision of care. While a provider may overlap two PPS, the logic appoints the Medicaid member and the provider to one PPS.

Attribution for valuation was a one-time calculation conducted in DSRIP Year 0 based on the PPS original application which indicated the project selection, provider network, and project speed and scale commitments. Attribution for valuation determined the potential funds that the PPS could earn as well as the distribution of funds if metrics and milestones are achieved.

Attribution for performance is calculated monthly throughout DSRIP Implementation Years 1-5 based on the providers in each PPS network who are driving performance. The Performing Provider System can identify and analyze each provider's performance and develop strategic activities to transform workflow and member health outcomes to meet DSRIP goals. Attribution for performance is impacted by 1) the annual network re-opening where PPS may add providers for performance prior to the start of each Measurement Year and 2) the DSRIP Year 3 Midpoint Assessment, which allowed the one-time opportunity to remove up to, but not more than, 10% of partners from their network.

The attribution, valuation, and demographic information for this PPS is listed below. This information provides basic foundational knowledge for the research team as research activities roll out each year for each PPS.[1]

Address: 120 Washington Street, Suite 230, Watertown, NY 13601
Website: www.northcountryinitiative.org/dsrip.html
Counties Served: Jefferson, Lewis, and St. Lawrence
Attribution for Performance: 39,755
Attribution for Valuation: 61,994
Total Award Dollars: $78,062,821
Funds Flow as of Mid-Point Assessment through September 2016[1]: Distributed 66.69% of the DSRIP funding it earned to date ($11,688,960.97)

3.b North Country Initiative PPS selected projects with description and reason

DSRIP projects are organized into Domains, with Domain 1 focused on overall PPS organization and Domains 2-4 focused on various areas of transformation. In Domain 2, system transformation, each PPS selected two to four projects with the addition or exception of project 2.d.i. Domain 3 focused on clinical improvement and each PPS selected two to four projects in the domain. Domain 4 focused on population health and each PPS selected one to two projects from the domain. The table below describes the DSRIP-associated projects selected by North Country Initiative PPS and the reasons the PPS provided for selecting them. The project identification codes in the first column correspond to project domains and titles developed by NYS DOH and are defined in the NYS DSRIP Program Project Toolkit[2].

1 This information was obtained from the DY2 Q3 IA Mid-Point Assessment Report dated December 2016 available on the DSRIP website, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/index.htm. Updated funds flow information will be provided in the 2019 PPS report.

2 Available at www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

Project	Brief Description	Selection Reason (Provided by Samaritan PPS, now known as North Country Initiative PPS, in their Application)
Create Integrated Delivery Systems		
2.a.i	Create integrated delivery systems that are focused on evidence-based medicine/population health management	ER visit rate 32% higher than NYS rate
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))	Primary care visit rates for Medicaid beneficiaries in the PPS area are 20% lower than the state rate
2.a.iv	Create a medical village using existing hospital infrastructure	Convert unutilized hospital space to be functional for coordinated care
Implementation of Care Coordination and Transitional Care Programs		
2.b.iv	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions	Critical need to increase coordination between inpatient and outpatient settings using a more patient-centered approach to care
Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations		
2.d.i	Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community-based care	Often the only contact the uninsured and Medicaid non-utilizing and low-utilizing populations have with the health care system is through the ED
Behavioral Health		
3.a.i	Integration of primary care and behavioral health services	Mental illness is the single highest cause of preventable inpatient admission and ED visits
Cardiovascular Health—Implementation of Million Hearts Campaign		
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	The leading cause of death and the second leading cause of premature death in the PPS region is heart disease
Diabetes Care		
3.c.i	Evidence-based strategies for disease management in high risk/affected populations (adults only)	Diabetes is the fourth leading cause of preventable Medicaid hospitalizations
3.c.ii	Implementation of evidence-based strategies to address chronic disease – primary and secondary prevention projects (adults only)	40% of Medicaid beneficiaries indicated diabetes as a concern. Fourth leading driving of inpatient admissions and ED use. Chronic diseases are leading cause of death in Lewis County
Promote Mental Health and Prevent Substance Abuse (MHSA)		
4.a.iii	Strengthen mental health and substance abuse infrastructure across systems	Nearly 80% of the population surveyed identified substance abuse as the leading health problem in the region
Prevent Chronic Diseases		
4.b.ii	Increase access to high-quality chronic disease preventive care and management in both clinical and community settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)	Chronic lower respiratory diseases and cancer are among the top 3 leading causes of death within the PPS region

4. NORTH COUNTRY INITIATIVE PPS FINDINGS

North Country Initiative PPS is an alliance of clinical and social service providers with an organizational goal to improve the quality of care and health for Medicaid patients and uninsured populations in Jefferson, Lewis, and St. Lawrence counties. North Country Initiative PPS selected 11 projects, described above, and has 500 providers, facilities, and community-based organizations in addition to six hospitals as their partners. The goals of the North Country Initiative are[3]:

- Improving the quality and efficiency of care for the rural, under-served population
- Providing accessible, effective, high-quality health care
- Aligning health system partners with payers to drive clinical improvement and add value to patient care

3 This information was obtained from the PPS website, northcountryinitiative.org.

- Implementing evidence-based medicine to enhance patient outcomes

This report contains interwoven findings from data collected in the North Country Initiative PPS key informant interviews, Partner Survey, and patient survey. The report highlights both the successes and challenges faced by participants in the implementation and operation of DSRIP. During this data collection period, special attention was taken to collect retrospective data from DSRIP Demonstration Years 0-2 as well as to collect current implementation and process data from the first half of Demonstration Year 3, which was the time period concurrent with data collection. Findings are organized into six sections:

a) North Country Initiative PPS formation

b) North Country Initiative PPS satisfaction, perceived effectiveness, and changes due to DSRIP

c) North Country Initiative PPS successes

d) North Country Initiative PPS challenges and recommendations for change

e) North Country Initiative PPS value based payments

f) North Country Initiative PPS patient care

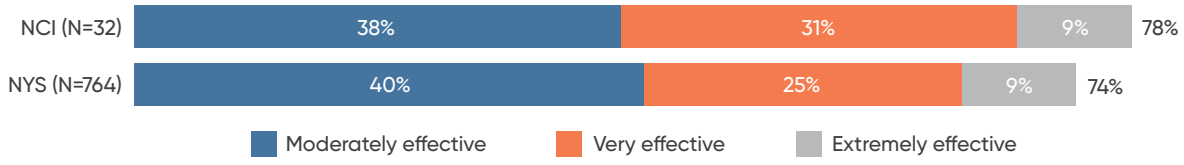
4.a North Country Initiative PPS formation

North Country Initiative PPS began as a clinically integrated network formed in 2007 to meet the needs of the region, including the local military base, Fort Drum. These clinically engaged partners provided a head start when it came to building the foundation of the original Samaritan PPS, which is now a CMS-approved NewCo known as North Country Initiative (NCI). Due to this groundwork, there was already strong participation from hospitals and physicians, and the PPS was aware of problem areas to address. However, covering such a wide geographic area was a barrier to implementation. There was difficulty in bringing partners together for meetings, as well as in creating a care network over such large distances in a historically underserved area. The North Country Initiative service area has a high percentage of Medicaid recipients and a shortage of primary care professionals.

4.b North Country Initiative PPS satisfaction, perceived effectiveness, and changes due to DSRIP

Over three-quarters (78%) of respondents to the North County Initiative PPS Partner Survey perceived the DSRIP program overall to be at least moderately effective (9% extremely effective, 31% very effective, 38% moderately effective), with less than one-fourth rating it as slightly effective (18%) or not effective at all (3%). These ratings were slightly more positive than those found statewide. (See Figure 1.)

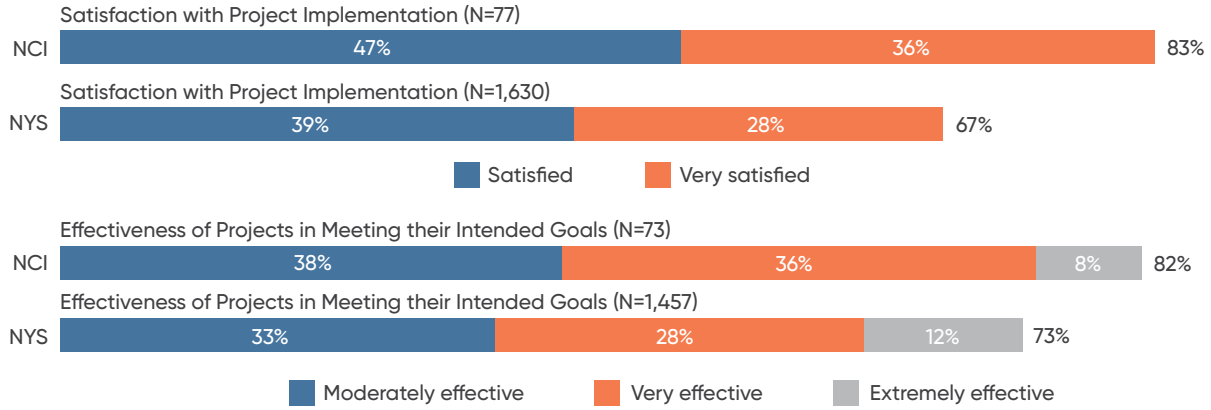
Figure 1. *Partner Survey: DSRIP effectiveness*



There were 25 responses to an open-ended follow-up question asking in what ways DSRIP was effective or ineffective. A total of 11 respondents discussed DSRIP effectiveness, eight discussed ineffectiveness, and six discussed both effective and ineffective aspects. Responses focused on effectiveness tended to discuss the increased collaboration between organizations, which increased patient access to services, and emphasized patient support needs between or outside health checkups. Examples of ineffectiveness were more varied, but the need for more resources (financial and otherwise) was mentioned multiple times.

Partner Survey respondents were asked about their experiences with up to three projects. Because these items were asked about each project separately, some respondents could provide more than one response. At least 80% of responses indicated that partners were satisfied or very satisfied with the implementation (83%) and operation (current operation: 83%; overall operation in Years 0-2: 84%) of their projects. Most responses (82%) indicated that the projects were at least moderately effective in meeting their intended goals; only 12% of the responses rated the projects as only slightly effective, and 5.5% as not effective at all. These responses were more positive than those found statewide. (See Figure 2.)

Figure 2. *North Country Initiative PPS Partner Survey: Project satisfaction and effectiveness*



North Country Initiative PPS participants were also asked which issues most affected their perceptions of the projects' effectiveness. Collaboration between partners was the main factor for 25% of responses. Most of these comments focused on positive aspects of collaboration, including the feeling of community within the PPS and the inclusion of community-based organizations in patient care and planning. Negative responses were about the unequal inclusion of some organizations and the room for further improvements.

Patient engagement was also a common factor in assessing a project's effectiveness more positively. About one-quarter of respondents discussed positive developments, such as patients becoming more involved and knowledgeable about their treatment. One group enrolled Medicaid clients in a diabetes program, something they revealed would never have occurred prior to DSRIP. Several respondents noted meaningful increases in patient access to care, with visits available more frequently and appointments with multiple types of providers scheduled on the same day to accommodate patients with transportation barriers. Additionally, respondents noted benefits specifically in mental health services; a provider may now be available in-house, whereas outside referrals used to have months-long waits.

Over three-quarters (78%) of North Country Initiative PPS respondents reported that DSRIP changed the way their organization provided services (22% said it had not). This is slightly higher than statewide results (Figure 3). A total of 23 respondents answered a follow-up question asking how DSRIP changed the way their organization provides services. Of those, 14 noted changes involving collaboration between providers or integration of behavioral health services and primary care. In the words of one respondent:

> *DSRIP has helped our organization provide more consolidated care management services. This effort has helped patients and providers to both understand that we are a team working towards our patients' health.*
> ***– Partner Survey respondent***

Figure 3. *NCI PPS Partner Survey: "Has DSRIP changed the way your organization provides services?"*

4.c. North Country Initiative PPS successes

Stakeholders spoke of many successes through Demonstration Years 0-3, including coordination with other PPS in the area to minimize duplication of effort. This cooperation was facilitated by pre-existing relationships between the PPS organizations prior to DSRIP. These PPS now hold compliance training and operate additional (non-DSRIP) initiatives together, increasing collaboration across PPS in the region.

Engaged providers also reflected positively about new cooperation models due to DSRIP:

> *We had three Medicaid clients participate in our most recent 16 week [redacted] program and follow-up. This would have been unheard of before we began receiving physician referrals. These are individuals who not only reduced their [redatced] risk but have reduced their weight, formed friendships and social bonds, and become participating members. These are the things that bring lasting change to their lives and the lives of their families.* ***– Partner Survey respondent***

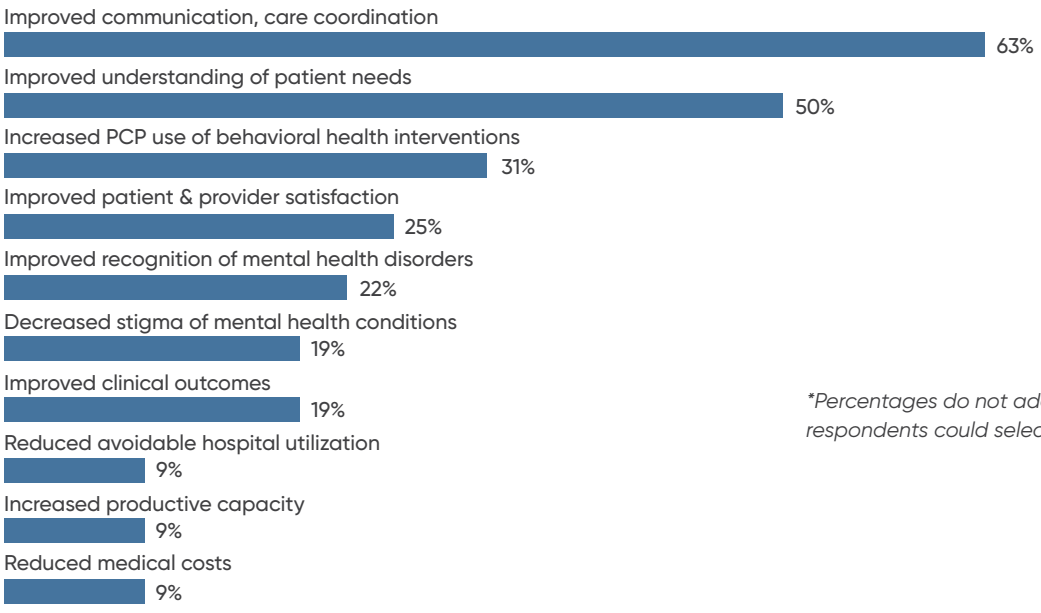
Providers also indicated greater patient engagement achieved through outreach and education. This has facilitated patient-centered care, thereby improving patient utilization of the health care system.

> *While affecting change at the level of individual thought and behavior is quite difficult, I believe this project is making strides to bring ED/hospital use to the level of conscious awareness in the target population, and to encourage the target population to engage in the desired behaviors.* ***– Partner Survey respondent***

Integrating behavioral health and medical care made a notably positive impact, resulting in the addition of new services as well as strengthening care coordination. Providers shared that in-office counseling for depression or chronic pain, consolidation of care management services, patient recognition and appreciation for integrated services, heightened awareness and use of community-based services, and increased follow-up after hospital discharge led to better care.

In the North Country Initiative PPS Partner Survey, DSRIP was most frequently said to have led to more coordinated care due to improved communication (63%), improved understanding of patient needs (50%), and increased primary care provider use of behavioral health intervention (31%).

Figure 4. *NCI PPS Partner survey: DSRIP benefits (N = 32)*



**Percentages do not add up to 100% because respondents could select more than one item.*

4.d North Country Initiative PPS challenges and recommendations for change

Study participants offered a number of challenges and associated recommendations for change within health care provider organizations, for the PPS as a whole, and for the NYS DOH DSRIP program.

4.d.i Recommendations for change within health care provider organizations

When asked to recommend changes to the current operation of their project within their organization, there was a wide variety of responses. Some North Country Initiative PPS respondents were interested in taking another step forward (e.g., expanding DSRIP services to a wider population), while others focused on addressing current challenges (such as creating more collaborative relationships, switching to electronic medical records, or improving methods of identifying high-risk patients). One-fifth of respondents noted a need for increased financial resources to hire additional staff.

4.d.ii Recommendations for change for North Country Initiative PPS

When asked to focus on the operation of their project within North Country Initiative PPS, more than half of Partner Survey respondents (56%) stated that they would not recommend any changes. A small group described financial burdens of DSRIP, either due to increased staffing or compliance standards or because of difficulties in receiving reimbursements. Consistent with analysis of the partner survey data found statewide, one respondent described the challenges caused by calling DSRIP projects by their number and letter titles (e.g., "2.a.ii".), saying:

> *It is kind of like calling a patient the gallbladder in 211 instead of by their name. These initiatives and feedback would be much more meaningful to myself and my staff if they were called what they are, not letters and numerals… I understand care management as care management and PCMH[4] as PCMH, not 2.a.ii.*
> ***– Partner Survey respondent***

4.d.iii Recommendations for change for New York State Department of Health

A total of 21 respondents offered recommendations for improvements for the DSRIP program overall. Three expressed concerns with sustainability, suggesting DSRIP should continue past the current grant dates, and two requested increased funding for facilities or innovative community projects. Another major topic was programmatic burdens and the scope of their projects. Overall, they would like to see a prioritization of outcomes to better manage their resources and reduction in administrative work:

> *Establish and prioritize desired outcomes at a state level. We now face a broad spectrum of initiatives that are all competing for limited resources. Profit margins are decreasing and the demands are increasing. A narrower focus on the most important matters would enable a better use of our organization's resources.*
> ***– Partner Survey respondent***

There were also calls for more timely data:

> *And, it would be wonderful if PPS could have access to our milestone performance in a more timely manner; it is difficult to try and achieve a target when we are referencing data that is already several years old.*
> ***– Partner Survey respondent***

And finally, some participants suggested that DSRIP could not respond to the actual needs of Medicaid patients because it was not holistic enough in its approach or because the existing health care structure would prevent change:

> *Overall the complexity of the needs at the local level run up against an outdated regulatory system which hampers speed and flexibility, and which restricts funding. This is compounded by the inability of service providers to change their care model in anticipation of service needs driven by funding. This is a significant public health demonstration project which decades of organizational structure make exceptionally complex to implement. Reduce the competing regulatory barriers to service and funding.*
> ***– Partner Survey respondent***

4 Patient-Centered Medical Home

4.e North Country Initiative value based payments (VBP)

When asked about preparations for switching to value based payments, nearly three-quarters (71%) of the North Country Initiative PPS Partner Survey respondents said their organizations had already made changes to prepare for value based payments. Over two-thirds characterized themselves as "very knowledgeable" (16%) or "somewhat knowledgeable" (53%) about value based payment (25% only a little knowledgeable, 6% not at all knowledgeable). This was a lower percentage than found statewide (Figure 5).

Figure 5. *NCI PPS Partner survey: Understanding of value based payments*

Even with these positive responses regarding their knowledge of value based payments, 87% of respondents revealed that they needed more resources or knowledge for the shift to value based payments. Some respondents noted that community-based organizations especially needed more information:

> *More concrete help must be provided in the managed care and value based payment contracting arena. It is just too complicated.* ***– Partner Survey respondent***

> *There should be more individualized support for community-based organizations to become involved. DSRIP is a complicated program to understand if you are a non-billing agency that would provide excellent community services to consumers to prevent hospitalization. Many of the meetings were not always novice friendly.* ***– Partner Survey respondent***

4.f North Country Initiative PPS patient care

Patient experiences were assessed using the CAHPS patient survey and the Partner Survey of providers. For the most part, patients were satisfied with their health care providers and their care coordination, and health care providers generally perceived that DSRIP was improving care through improved coordination.

4.f.i Patient perspectives

CAHPS surveys completed by 532 Samaritan PPS (now known as North Country Initiative PPS) patients in Demonstration Year 1 and 363 patients in Demonstration Year 2 showed that in general, patients were satisfied with their primary care providers. Over 80% gave their provider a high rating; received good care coordination; and received timely appointments, care, and information. More than 90% felt their provider was a good communicator and experienced helpful, courteous, and respectful office staff. Between Demonstration Years 1 and 2, there were small changes in some of these scores, but until more years of data are collected and it is possible to see a trend over a longer period of time, it is impossible to say whether these changes were meaningful. Figure 6 displays these figures, as well as those for all PPS.

Figure 6. *CAHPS survey: Patient satisfaction with providers, DY1 and DY2*

Demonstration year	Rated provider 8 or above	How Well Doctors Communicate with Patients[5]	Care Coordination[6]	Getting Timely Appointment, Care, and Information[7]	Helpful, Courteous, and Respectful Office Staff[8]
DY1 NCI	84%	94%	84%	88%	95%
DY1 All PPS	84%	92%	84%	85%	90%
DY2 NCI	83%	92%	87%	83%	95%
DY2 All PPS	82%	91%	83%	83%	89%

An established relationship with a primary care provider has been shown to improve health outcomes, reduce the cost of care overall by providing preventive interventions, facilitate access to the rest of the health care system, and reduce preventable hospital visits (Starfield, Shi, & Macinko, 2005). Thus, the CAHPS survey included items about continuity of care. For more than three-fourths of respondents (79% in DY1; 82% in DY2), the provider from whom they received care was the provider they usually saw if they needed a check-up, wanted advice about a health problem, or got sick or hurt. Similar percentages (78% in DY1; 79% in DY2) were seeing this provider for at least one year (Figure 7). About one-third were seeing the provider for five years or more; 34% in DY1 and 35% in DY2.

Figure 7. *CAHPS Survey: Patient relationship with provider, DY1 and DY2*

Demonstration year	The patient saw usual provider	Patient had been seeing provider for at least one year
DY1 NCI	79%	78%
DY1 All PPS	79%	74%
DY2 NCI	82%	79%
DY2 All PPS	81%	76%

4.f.ii North Country Initiative PPS Partner perspectives

All (100%) respondents felt that patients were experiencing better care since the launch of DSRIP. Over three-fourths of responses (84%) indicated that projects were changing patient care for the better[9]. Nearly two-thirds (62%) felt that DSRIP improved community care at their organizations. Over three-quarters (81%) believed that DSRIP was positively changing population health.

5 This composite score was based on the following items: In the last 6 months:
- How often did this provider explain things in a way that was easy to understand?
- How often did this provider listen carefully to you?
- How often did this provider show respect for what you had to say?
- How often did this provider spend enough time with you?

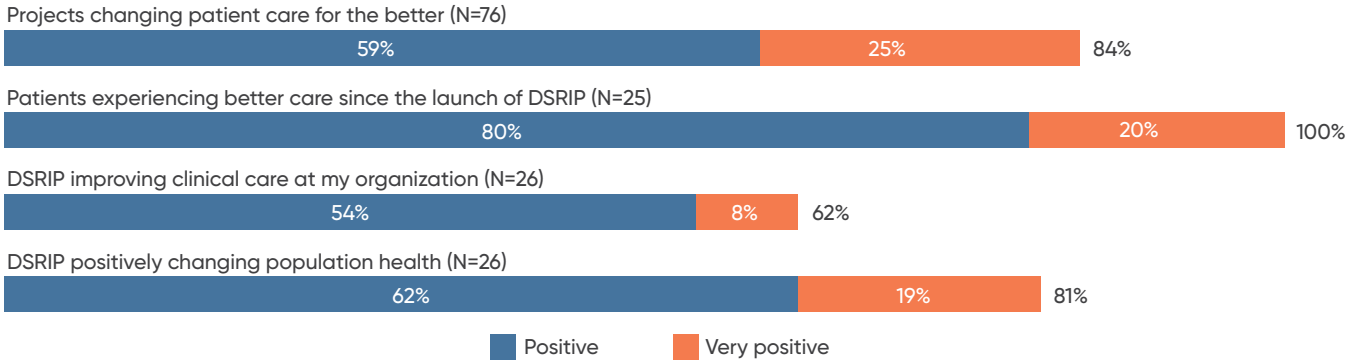
6 This composite score was based on the following items: In the last 6 months:
- How often did this provider seem to know the important information about your medical history?
- When this provider ordered a blood test, x-ray or other test for you, how often did someone from this provider's office follow up to give you those results?
- How often did you and someone from this provider's office talk about all the prescription medicines you were taking?

7 This composite score was based on the following items: In the last 6 months:
- When you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?
- When you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?
- When you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

8 This composite score was based on these two items: In the last 6 months:
- How often were clerks and receptionists at this provider's office as helpful as you thought they should be?
- How often did clerks and receptionists at this provider's office treat you with courtesy and respect?

9 This item was asked for up to three projects per respondent.

Figure 8. *NCI PPS Partner Survey: Patient care*



When the North Country Initiative PPS Partner Survey respondents were asked about the benefits of DSRIP, DSRIP was said to have improved communication between providers, leading to more coordinated care, as well as improved understanding of patient needs. See Figure 4 in the "Successes" section.

Partners noted real changes to patient care due to DSRIP related resources and care coordination:

> *Behavioral health was one of the longest waits for referrals for our patients…the exponential increase in behavioral health needs of our pediatric patients has not kept up with the amount of providers available. This program has allowed us to coordinate a counselor who is in our office available to our patients. It has been incredibly helpful to both our patients and our staff. It never would have happened without the help of the [North Country Initiative].* ***– Partner Survey respondent***

Other partners were more tepid in their response, noting that while they saw change, it was too early to tell its impact:

> *This is a slow-moving project and I think hospitals will be very difficult to get on board to connect patients to community-based organizations upon discharge. I have not seen the warm hand-off yet to community-based organizations, and I think hospitals are having a hard time getting on board to use direct messaging to make referrals. But, there has been improvement in communication between agencies about local services. I think it is too soon in the development to expect large change with the patients. It is taking a long time to get everyone to utilize the same system and same set of Corporate Compliance/protocols. This will take time.* ***– Partner Survey respondent***

5. SUGGESTED RECOMMENDATION FROM PARTNERS AND FROM RESEARCH FINDINGS FOR NORTH COUNTRY INITIATIVE PPS

1

Increase provider availability and responsiveness during patient care transitions. Although some partners reported improved service integration, care transition between providers is still a challenge. The PPS may consider ensuring that providers, especially those for behavioral health, are available to accept transitioning patients and are responsive to patients' needs such as follow-up visits after emergency department utilization and connections to additional services. North Country Initiative PPS may consider seeking stakeholder advice from its partners in order to create trainings or tools that further strengthen care transitions.

2

Continue support of projects that improve health care for historically underserved areas. While some participants explained that the vast geographic area covered by North Country Initiative led to challenges in providing care to medically underserved areas, they also noted that DSRIP brought

2

together partners across the region to expand services. However, some participants reported that the breadth of needs in rural locations was still seriously underestimated. Due to the largely rural settings of the region, it is vital that North Country Initiative PPS continues to provide financial, infrastructural, and best practice resources to providers who serve these communities so that they continue to expand and transform access to care for their patients.

3

Continue value based payment training. Despite provider-based assessments that they were largely knowledgeable of value based payment, the vast majority of stakeholders requested more resources and knowledge. For example, several community-based organizations in North Country Initiative PPS reported that the value based payment trainings had been oriented towards more experienced stakeholders. Future value based training may focus on integrating community-based organizations into the model and acknowledging different levels of experience in this arena. If the PPS has not already done so, it may consider seeking out specific knowledge gaps in value based payment and creating more materials to support its partners in this transition period.

6. CONCLUSION AND PLANS FOR FUTURE RESEARCH

North Country Initiative PPS activities and stakeholder feedback from Demonstration Years 0-3 indicate the PPS is making progress towards meeting its goals and transforming health care. Future research is indicated to track this progress over time. Two subsequent PPS-specific reports will be provided in 2019 (covering the second half of Demonstration Year 3 and the first half of Demonstration Year 4) and 2020 (covering the second half of Demonstration Year 4 and Demonstration Year 5).

North Country Initiative PPS and its stakeholders should also reference the 2018 Statewide Annual Report by the Independent Evaluator for the New York State DSRIP program. This report includes summaries of major DSRIP evaluation findings statewide to highlight areas of success and areas in need of improvement. Statewide Annual Report findings from Research Cycles 2 and 3 will also be published in 2019 and 2020 respectively.

Plans for future research within each of the Independent Evaluator's research components are described below.

Implementation and process evaluation

The implementation and process evaluation team's data collection activities for the next two years will include:

- Key Informant Interviews: In the summer of 2018, the IE will schedule telephone interviews with PPS staff responsible for projects to gather detailed insights on each PPS-selected project. In 2019, the IE will again conduct telephone interviews with PPS senior leadership. These will function as follow-ups to their interviews regarding DY0-DY3. Questions will focus on shifts to payment for performance, as well as other DSRIP-related changes.
- Partner Focus Groups: The IE will organize focus groups in the remaining NYS regions with project partners over the next two years. In 2018, these will be focused on the New York City area.
- Partner Survey: The electronic survey of approximately 2,400 engaged partners will be administered once in each of the remaining research cycles. PPS will be contacted to assist in updating lists of DSRIP-engaged partners for the survey.
- Patient Data: Secondary analysis of the CAHPS survey will be conducted for each research cycle.

Time series analysis

The time series analysis team acquired access to the Medicaid Data Warehouse (MDW) and the Statewide Planning and Research Cooperative System (SPARCS) data in 2018. They will begin their analysis by performing a descriptive analysis of the performance metrics used by NYS. This will provide a comprehensive view of how these measures changed for the NYS Medicaid population attributed to DSRIP. Then, all-payer data from SPARCS will be matched with the MDW to study the trends in both the Medicaid and non-Medicaid population in the pre- and post-DSRIP periods. If a proper comparison group cannot be established, then further efforts will be made to create such a group (e.g. through synthetic control).

Comparative analysis

The comparative analysis team will use quantitative data to assess relative PPS performance over time. This work will be supplemented by qualitative data emanating from the implementation study to further contextualize the findings.

References

Creswell, J.W. (2013). *Qualitative inquiry and research design: Choosing among five approaches (3rd Edition).* Sage Publications, Inc.: Thousand Oaks, CA.

Creswell, J.W. & Piano Clark, V.L. (2003). *Designing and conducting mixed methods research (2nd Edition)*. Sage Publications, Inc.: Thousand Oaks, CA.

Patton, M.Q. (2002). *Qualitative research and evaluation methods (3rd Edition)*. Sage Publications, Inc.: Thousand Oaks, CA

Teddlie, C. & Yu, F. (2007). Mixed methods sampling: A typology with examples. Journal of Mixed Methods Research, 1(1), 77-100.

Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly, 83*(3), 457–502. http://doi.org/10.1111/j.1468-0009.2005.00409.x

Appendix

I. KEY INFORMANT INTERVIEW GUIDE: RESEARCH CYCLE 1

1. *(If knowledgeable about PPS development)* How was your PPS initially formed?
   (If not knowledgeable about PPS development) How did you get involved with DSRIP teams or projects?
2. What are some of the biggest challenges your PPS experienced during the early phases (years 0-2) of project implementation?
3. What are some of the biggest successes that your PPS experienced during the early phases (years 0-2) of project implementation?
4. Please tell us about PPS committees that are related to its governance, and about the effectiveness of the committees in meeting its goals and objectives.
5. What data are being collected by your PPS and/or NYS DOH that you believe to be the most important to understanding overall DSRIP program success?
6. From your perspective, how valuable is the account support provided by NYS and its consultants? How valuable is the project implementation support?
7. In your view, has DSRIP changed the health care system?
8. Is there anything you would like to comment on regarding DSRIP in general?

II. STATEWIDE PARTNER SURVEY METHODOLOGY

II.a Statewide Partner Survey sampling & response rates

The section below discusses the methodology for the statewide Partner Survey. Numbers provided are NY statewide. The number of surveys received and response rate for this PPS are described in Section 2.b.

An initial sample of engaged and not engaged providers was developed from the Point In Time Demonstration Year 2 files for each PPS. Some providers appeared in samples for multiple PPS and some for only one. Each PPS was sent a list of providers associated with their PPS and were asked to first update the status for providers (i.e., change status to "not engaged" if a provider was no longer involved, or change to "engaged" if a provider was now participating in a project), and second to provide contact and engagement status information for any new providers. All but one of the PPS responded and returned an updated list of engaged providers; providers for the remaining PPS was determined by the Demonstration Year 2 list alone.

Contacts for each PPS were asked to alert their provider network to the survey and encourage its completion. The research team then sent each engaged provider an e-mail asking the provider to complete the Partner Survey, with a personalized link to the survey in Qualtrics. In total, survey links were sent to 2,794 e-mail addresses. As some partners were part of several PPS, they received multiple requests for the survey.

Providers could be individual practitioners or organizations. In some cases, only one e-mail address was available for multiple providers (e.g., a medical practice may have provided one contact e-mail for multiple staff doctors, or a community-based organization with multiple involved staff members may have used one business e-mail). Further, some individuals received a survey link associated with their e-mail address but subsequently forwarded it to another member of their organization. As such, there is not a direct correspondence between e-mail address and individual respondents.

The survey was originally available for four weeks, then was extended for three more. As an incentive to complete the survey, participants were informed that three respondents would win a $100 Amazon gift card.

Potential participants who did not complete the survey were sent eight (8) reminders over the response period; some PPS also elected to send reminders of their own. A total of 1,235 completed surveys from unique individuals were returned from all PPS. A total of 315 respondents opened the survey but did not answer any questions, and 23 more were determined to be unusable for various reasons (e.g. two participants did not give a coherent response in any text box, including their name). These methods resulted in 897 usable responses, for a final response rate of 32%.

II.b Analytic methods: data preparation

Survey responses were first deduplicated. About 100 respondents opened the survey multiple times. In the case of multiple responses from one person (same name and organization provided), the more complete response was kept (e.g., if a participant opened the survey but did not complete anything past entering his or her name, and then reopened the survey later and completed it, the second entry was used). If they completed similar amounts of the survey each time, the first one was kept. If a participant had multiple survey entries and responded about different projects in each, the first three evaluations were kept. For example, if a participant responded about two DSRIP projects in one survey entry, then retook the survey and answered about another different project, the responses from the second survey were added to those of the first, and the second survey record was deleted.

Response data quality was then examined by PPS and project. Of the 1,753 potentially usable individual project evaluations received, 262 (15%) were for a project that was not implemented in the selected PPS. For example, across the sample, 70 responses were received for Project 2.a.ii in PPS that were not implementing 2.a.ii. When possible, these responses were recoded. Respondents were first assumed to have selected the correct PPS but the wrong project: if the organization or PPS was involved in a similar project in the same subdomain or grouping, the response was recoded. If the selected PPS was not involved in a similar project but the participant had also responded about another PPS which was involved in that project, the PPS was corrected. Using these procedures, 202 responses were corrected. A total of 61 responses were unable to be recoded and so these were not included in further analyses, leaving 1,691 project-based responses.

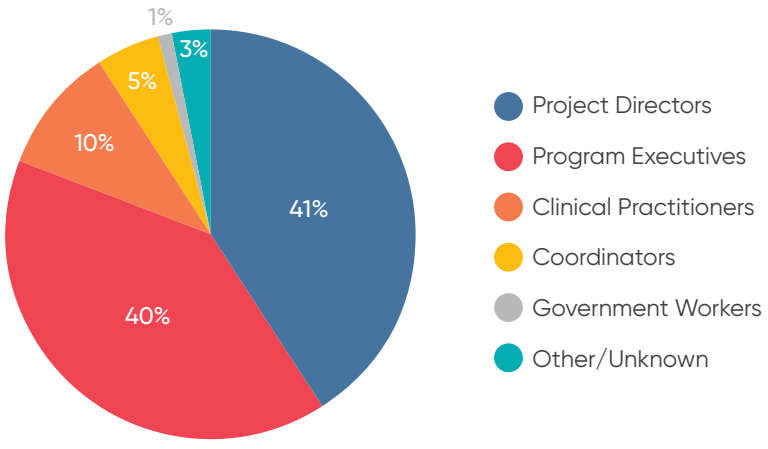
II.c Respondent Characteristics

In total, there were 897 usable unique responses to the survey, where participants entered their name or the name of their organization or their title, noted in how many DSRIP PPS they were involved, and selected the first project for evaluation. A total of 32 of these participants then did not answer any further questions but were not excluded from initial analyses.

The majority of respondents were administrators, project managers, or directors of various types (N=364, 41%) and program executives (vice presidents, presidents, executive directors, or C-level executives, N=361, 40%). Approximately 10% (N=92) of respondents were clinical practitioners (doctors, nurses, social workers, or clinical supervisors). About 5% (N=47) were administrative assistants, coordinators, or office managers; five (5) were county commissioners or deputy commissioners; and 25 were other types of workers (consultants, board members, data analysts and researchers, IT support). Three participants did not provide their position.

Respondents reported working at 796 different organizations. The largest group of respondents (N=254, 28%) were part of community-based

Respondent Characteristics



organizations, followed by individuals working in a practitioner's office or private practice (N=138, 15%) or a clinic (N=46, 5%). Another 15% worked at a hospital (N=134), 13.5% (N= 121) at an organization focusing on mental health or substance abuse, and 13% (N=114) at a nursing home, rehabilitation facility, or hospice/palliative care center. The remaining participants were employed by case management or health home programs (3%, N=29), city or county government departments (e.g., County Department of Health, 4%, N=35), pharmacies (0.6%, N=5), or some other organization (e.g., nurse staffing agency, insurance company, 2%, N=19). Two participants did not provide their organization.

One-third (33%, N=298) of respondents reported being involved in only one project, one quarter (24%, N=214) were involved in two, and 43% (N=385) were involved in at least three. However, in evaluative responding, most participants (41%, N=365) responded about their involvement in one project, 22% (N=201) about two different projects, and 37% (N=331) about three. The majority of participants (80.5%, N=722) chose to respond about projects within just one PPS; 12% (N=109) responded about projects in two different PPS and 7% (N=66) responded about projects in three different PPS.

III. PARTNER SURVEY INSTRUMENT

1. What is your name?

2. What is the name of your organization?

3. What is your position?

4. How many PPS-selected DSRIP projects are you involved with and knowledgeable about?

   If you are involved with more than 3 DSRIP related projects at your organization, please think of the 3 projects with which you are most involved. The project(s) may be within one PPS or several projects across multiple PPS depending on your service area and involvement.

5. Using the drop-down menu below, please indicate the first project you are involved with and the corresponding PPS.

   PPS:
   Project:

6. Please indicate your level of satisfaction with <Project> implementation as related to working with <PPS>.

   Very satisfied (1)
   Satisfied (2)
   Neither satisfied nor dissatisfied (3)
   Dissatisfied (4)
   Very dissatisfied (5)
   Not applicable (6)
   I don't know (7)

7. Please indicate your level of satisfaction with the current operation of <Project> as related to working with <PPS>.

   Very satisfied (1)
   Satisfied (2)
   Neither satisfied nor dissatisfied (3)
   Dissatisfied (4)
   Very dissatisfied (5)
   Not applicable (6)
   I don't know (7)

8. How satisfied were you with <Project> operations at your organization overall during Demonstration Years 0-2 (2014-2017)?

   Very satisfied (1)
   Satisfied (2)
   Neither satisfied nor dissatisfied (3)
   Very dissatisfied (4)
   Not applicable (5)
   I don't know (6)

9. What would you change about current operation of the project within <PPS>?

   _____

10. What would you change about the current operation of the project within your organization?

    _____

11. Please indicate the degree of change to which you perceive the project is changing patient care.

    Very positive change (1)
    Positive change (2)
    No change (3)
    Negative change (4)
    Very negative change (5)

12. How effective do you perceive the project to be at meeting its intended goals currently?

    Extremely effective (1)
    Very effective (2)
    Moderately effective (3)
    Slightly effective (4)
    Not effective at all (5)
    I don't know (6)

13. Why do you feel this way?

    _____

<Items 5 through 13 were repeated up to three times for respondents participating in more than one project.>

14. One focus of DSRIP was to integrate primary, specialty, and behavioral health care. Has the clinical care at your organization changed since DSRIP was initiated?

    Yes, very positive change (1)
    Yes, positive change (2)
    No change (3)
    No, negative change (4)
    No, very negative change (5)
    I don't know (6)
    Not applicable, my organization does not provide clinical services (7)

15. Have you observed any of the following benefits to primary care and behavioral health services integration? (Please select all that apply).

    Improved communication leading to more coordinated care (1)
    Improved recognition of mental health disorders (2)
    Increased primary care providers (PCPs) use of behavioral health intervention (3)
    Decreased stigma of mental health conditions (4)

Improved understanding of patient needs (5)
Improved patient and provider satisfaction (6)
Improved clinical outcomes (7)
Reduced avoidable hospital utilization (8)
Increased productive capacity (9)
Reduced medical costs (10)
Other (please specify): (11) _____
N/A (12)

16. In your view, are patients experiencing better care since the launch of DSRIP?

Yes, very positive change (1)
Yes, positive change (2)
No change (3)
No, negative change (4)
No, very negative change (5)
I don't know (6)

17. Another focus of DSRIP was population health interventions. Do you believe DSRIP has changed any aspect of population health within your service area?

Yes, very positive change (1)
Yes, positive change (2)
No change (3)
No, negative change (4)
No, very negative change (5)
I don't know (6)

18. Has DSRIP changed the way your organization provides services?

Yes (1)
No (2)
I don't know (3)

19. If yes, in what ways has DSRIP changed the way your organization provides services?

_____

20. How do you characterize your understanding of value based payment?

Very knowledgeable (1)
Somewhat knowledgeable (2)
Only at a little knowledgeable (3)
Not at all knowledgeable (4)

21. Have you made changes to your practice or organization to prepare for value based payment?

Yes (1)
No (2)
I don't know (3)

22. Do you require more resources/knowledge for the shift to value based payment?

Yes (1)
No (2)
I don't know (3)

23. How effective do you perceive DSRIP to be overall?

    Extremely effective (1)
    Very effective (2)
    Moderately effective (3)
    Slightly effective (4)
    Not effective at all (5)

24. In what ways is it effective or ineffective?

    _____

25. Please share any suggestions you may have for state-level changes or program improvements for DSRIP as a whole.

2018

Delivery System Reform Incentive Payment (DSRIP) Program

Independent Evaluation

Annual Performing Provider System (PPS) Report for

North Country Initiative PPS

DSRIP Demonstration Year 0 – DSRIP Year 3

NEW YORK STATE | Department of Health

Center for Human Services Research
University at Albany State University of New York