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Patient Activation Measure (PAM)

2di

MARCH 17, 2021

CARE COMPASS NETWORK
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Introduction

Care Compass Network is a Performing Provider System formed for the purpose of administering the Delivery System Reform Incentive Payment (DSRIP) program in a nine-county area of New York, including Broome, Chemung, Chenango, Cortland, Delaware, Schuyler, Steuben, Tioga, and Tompkins. CCN is a 501(c)(6) organization with five area health systems as corporate members. In addition, CCN has approximately 175 total partners, which include providers of medical care, mental health care, substance use disorder services, as well as a wide range of community-based organizations, whose services support underserved populations in the areas of food/nutrition, transportation, substance use, mental health, material support, health literacy, care navigation and coordination, housing, parenting and young children, etc. Through the course of the DSRIP program, CCN implemented twelve different projects with the objective of transforming the health care system into a value-driven network capable of providing high quality care and services to Medicaid members. System transformation, from the perspective of CCN and its partners, encompasses a wide range of changes, including the following:

- Greater collaboration and coordination between clinical and social care service providers
- Shift of services from inpatient and institutional settings to community and home
- A focus on addressing determinants of health, both social and clinical in nature
- Integration of services across domains, including mental/behavioral, physical, and social
- Promotion of self-management skills for both physical and mental needs
- Partner readiness for value-based contracts and development of key competencies

Now, at the conclusion of the DSRIP program, CCN is in a position to consider the lasting impacts that eleven DSRIP projects have had on Medicaid members, community members, and the health care eco-system at large. CCN's Population Health department, with input from many sources, has produced eleven project evaluation reports and score cards in order to best compare across projects, despite the differences in project objectives and reach. The findings of these report will inform CCN's next phase, including the use of CCN funding after September 2020, when the final phase of CCN partner contracts concludes.

Each project report reflects the findings from a mixed-methods evaluation. Qualitative information gathered from CCN staff, partners, Medicaid members, and community members contribute to the findings. In addition, the reports consider quantitative findings. Included in the report are findings on the scale and reach that CCN was able to achieve – the number of organizations engaged in the project and the number of Medicaid members engaged. CCN also considered the statistical relationship between project activities or services delivered to patient/clients and key patient outcomes from the DSRIP program including preventable emergency department visits, inpatient hospitalizations, and primary care engagement. Further, CCN considered the impact of the projects on several different quality indicators associated with project-specific DSRIP performance measures. All results are explained in detail throughout.

Data Sources

Information supporting this project evaluation comes from four primary sources. Each source of information contributes to the project scorecards, which allows for comparison across disparate projects.

To gather input from organizations intimately knowledgeable about the projects and their impact, we partnered with Research & Marketing Strategies to conduct structured in-depth interviews with partners

who participated in the projects. In total, 21 in-depth interviews were completed. CCN Project Managers identified candidates from partner agencies for interviews based on their involvement in project implementation and their role in the project. Candidates were invited to participate and their organizations were reimbursed a nominal payment to reflect the level of effort involved. Key themes assessed include patient outcomes, cost of care, lasting partnerships with other organizations, workforce development, and system transformation. Many interview questions were open-ended and allowed the respondent to comment freely, positively or negatively, about the effectiveness of the project. The questionnaire also used scale-based questions, which can easily be compared across respondents and projects.

CCN also gathered input on the same themes from partners at large through open dialogue at the four May 2020 Regional Performing Unit meetings (all held remotely via video conference call). In addition, a follow up survey using SurveyMonkey collected broader partner feedback on workforce development and system transformation using scale-based questions.

To gather information from Medicaid and community members, CCN leveraged the on-going, periodic electronic survey administered by RMS of a panel of Medicaid Members (self-identified) and community members. A brief survey tool was developed to gather high-level input on the activities that CCN and the DSRIP program at large promoted. Overall, the response rate was 14% (consistent with industry standards); 46 Medicaid members and 72 community members responded.

To gather input on the total CCN achievements for each project, we incorporated material from structured reports written by CCN Project Managers who are responsible for managing the project implementation, maintenance, milestone reporting to NY Department of Health, and payment to partners. Project Managers summarized project progress, noting major accomplishments, barriers, and options for sustainability.

Finally, to understand the impact of each project from a statistical perspective, CCN conducted a quantitative analysis to establish, at a person level, the link between project activities and patient outcomes, such as primary care engagement, emergency department visits, and inpatient discharges. Additionally, CCN considered project specific quality indicators and their link to the project activities. In each case, a cross-sectional analysis using data from July 2016 to June 2019 and the population of Medicaid members who were DSRIP attributed to CCN during Measurement Year 5 (July 2018 to June 2019). The data sources for these analyses included CCN project data, submitted to CCN by partners contracted for each project, and Medicaid Confidential Data pulled from the Salient Interactive Miner, a proprietary data mining tool made available to Performing Provider Systems like CCN for use under the DSRIP program.

Project Summary

Project 2di, “Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care” was a DOH required DSRIP 1.0 project for all PPS across NYS. The purpose of this project was to develop a standardized process for gathering patient health trends data to identify, engage, and navigate uninsured clients and Medicaid members considered to be non-utilizers or low-utilizers of health care services. The intent behind engaging this population was to help members establish relationships with primary care and ambulatory care so as to reduce avoidable Emergency Room Visits. To pursue this goal, CCN trained and supported a

network of providers and social service agencies across the PPS to administer the Patient Activation Measurement (PAM) survey and then use the results to navigate clients to appropriate services.

Through this project, CCN and partners were able to make gains in several areas. The PAM survey was introduced to CCN partners as a new tool to assess client needs and health behaviors. To complete a PAM survey, partners used the Flourish system, owned by Insignia Health[1]. This system introduced some partners to electronic record systems and underlined the importance of tracking patient/client trends over time. The PAM survey was used as a screening or onboarding tool to establish a baseline on clients to understand the needs and place them in the continuum of care. The PAM Survey project targeted the uninsured, non and low utilizers which helped navigate them to enrollment and redirected utilizing services again. Partners successfully integrated the PAM tool into high-volume need settings, including Department of Social Services (DSS), WorkforceNY, and local Free Clinics.

The project was successful from several different perspectives; however, CCN considers this project to have had a low impact on patient outcomes. As a tool for navigation, the PAM survey has merit. However, as a standalone activity, there are some meaningful drawbacks. The overall success of this project was limited by the difficulty embedding PAM surveys into clinical settings, such as Primary Care, Emergency Departments, and Dental Care. Another barrier CCN experienced in administering the 2di project was client resistance to sharing personal information via an unfamiliar survey or setting. That is, unless the survey is conducted in a setting where such information would naturally be shared, the survey recipient (client) may be unwilling to fully participate. Thus, the PAM survey may be most successful when deployed in settings where clients have a trusting relationship established and where the survey administrators (navigators, community health workers, care managers, etc.) can use the information gathered to personalize or enrich the services being provided.

Evaluation Results

This table summarizes the evaluation results. In order to readily compare across projects, a scoring matrix was created and reflects each study component. The detailed scorecard can be found in the appendix.

Table 1: Scoring Matrix (Calculation Details in the Appendix)

Evaluation Elements	Possible Points	Points Received
View from the Front Line: Partners		
In Depth Interviews with Partners	25	23.63
RPU Meeting input and Survey	10	7.75
Member Voice: CCN's Medicaid and Community Member Panels		
Panel Survey conducted by RMS	15	N/A
Community Accomplishments: CCN Project Managers		

[1] https://www.insigniahealth.com/products/flourish

Structured report by PMO, Follow up Interview	25	20.6
Performance Metric Impact: Population Health		
Statistical relationship between project activities and key health outcomes	15	0
Causal Effect	6	N/A
Cost Effectiveness Analysis	4	N/A
Overall (Out of 100)	**100**	**51.98**

Refer to the appendix for detailed scoring criteria

The CCN Project Management Office provided valuable input and insight about each project's major achievements, obstacles, best practices, and overall value. Project Managers have a unique perspective as a result of their knowledge of DSRIP program objectives and requirements, regular tracking of project activities and services, relationships with participating organizations, and knowledge of how project activities have been rolled out or implemented across the PPS. Despite explicit criteria from the Department of Health for project requirements, there was relatively broad latitude in how the requirements could be implemented. A critical component of any evaluation are the insights of those who are most familiar with project management, provided that there is objectivity in the assessment.

Best Practices

A key contributor to the success of this project was the integration between 2di and Community-based Navigation project activities (Project 2ci). A key objective of the Navigation project was to implement a care coordination model for working longitudinally with clients using efficient, consistent, and evidence-based protocols to ensure client needs are addressed appropriately and navigated effectively. Thus, by coordinating with these project activities, PAM survey data was effective in connecting clients with the health and Social Determinant of Health services they needed. Additionally, PAM surveys were effective in helping CBOs better understand their clients' needs and opportunities for engagement.

Key Quotes

Project 2di Project Manager, Emily Jones, noted that: "Prior to the PAM Survey project and even DSRIP, the uninsured population was increasing and utilization of services were decreasing causing gaps in care and understanding of services available. With the implementation of the PAM survey, dedicated outreach staff were strategically placed to "meet the clients where they are at" which in this case were high-need areas such as Department of Social Services, Workforce NY, and Free Clinics. This has allowed partnerships between Community Based Organizations and Government agencies address the needs of the client together."

Table 2: Total Project Engagement and Total CCN Spending	
Unique Organizations Engaged	47
Unique Members Engaged	27,486
Total Services provided (PAM Surveys Conducted)	29,175
DSRIP dollars paid to CCN Partners	291,750
Mean PAM Score	69.5
Mean PAM Level	3

Quantitative Findings
Regression Analysis

This section presents a quantitative regression analysis to establish a statistical relationship between the project activities and proxy measures for the DSRIP performance metrics. Performance metrics featured prominently in the DSRIP program, driving a significant portion of funding. The underlying question assessed in this section is: did the project make an impact on CCN's performance metric results? This is an important question as CCN considers areas of future investment and the overall return of participating in this DSRIP project.

For Patient Activation Measurement, we considered the impact of the PAM surveys on the likelihood that individuals experienced potentially preventable ED services (total and among those with a behavioral health diagnosis), inpatient hospital care, and ambulatory or preventive care. These measures are proxies for key DSRIP performance metrics, including Potentially Preventable ED Visits (total), Potentially Preventable ED Visits among members with previous Behavior Health diagnoses, Preventive or Ambulatory Care visits, and Prevention Quality Indicator (Composite), which captures potentially avoidable hospital care. These metrics were chosen for analysis based on a CCN Project Team analysis in 2016, which identified a probable impact of the project activities on the performance metrics.

The table below describes each Performance Metric and proxy measure as well as the study hypotheses. Through PAM surveys, it is possible to identify the social determinants of health and address associated needs in order to support an appropriate use of health services. By engaging a broad set of partners, both clinical and non-clinical partners, CCN sought to facilitate systematic changes and standardization of navigation, care coordination, and community health worker services. Thus, we hypothesize that the PAM program reduced the need for emergency services that may be better addressed elsewhere (i.e. potentially preventable) as well as the need for inpatient hospital care. Similarly, we hypothesize that PAM surveys are effective in connecting individuals to primary care services. Thus, we hypothesize that the PAM Surveys increased use of primary care services among actively engaged Medicaid members.

Table 3: Performance Metrics and Proxy Measures

Metric Name / Proxy	Description	Study Hypothesis
Potentially Preventable ED Visits, per 100 Members **Proxy measure**: Having one or more Potentially Preventable ED visits	The number of potentially preventable ED visits (based on CPT codes reported on claims) among Medicaid Members, as defined by the NYU metric definition (reference), per 100 members.	PAM surveys provided to individuals can help address underlying needs and direct individuals to services, thereby alleviating urgent needs which drive them to seek care in the ED. We hypothesize a decline in the likelihood that an individual has any ED visits after PAM survey.
Potentially Preventable ED Visits – Behavioral Health, per 100 Members **Proxy measure:** Having one or more Potentially Preventable ED visits, among members with a Behavioral Health diagnosis	The number of potentially preventable ED visits (based on CPT codes reported on claims) among Medicaid Members, as defined by the NYU metric definition. The analysis population is limited to members with a behavioral health diagnosis, per 100 members.	Same as above. We hypothesize that individuals with behavioral health diagnoses (mental health and substance use disorder) will be more likely to seek care and services in other settings following PAM surveys.

Prevention Quality Indicator – Overall Composite (#90) **Proxy measure:** Having one or more inpatient hospitalizations	The number of inpatient discharges, defined by revenue codes reported on claims.	PAM surveys provided to individuals can help address underlying needs and direct individuals to services, thereby alleviating urgent needs. We hypothesize that individuals will be less likely to require inpatient care following a PAM Survey.
Adult Access to Preventive and Ambulatory Care **Proxy measure**: Having one or more primary care visits	The percentage of members with one or more ambulatory and preventive care visits (defined by E&M Codes reported on the claim).	PAM Surveys provided to individuals can help address underlying needs and direct individuals to services, including primary care. We hypothesize that individuals will be more likely to use primary care services following PAM Surveys.

We used logistic regression models to statistically relate the performance metric proxy variables to the project activities – PAM Surveys. In this analysis, the data from July 2016 through June 2019 were pooled for cross-sectional analysis. We tested whether Medicaid members who received PAM surveys were less likely to also have one or more Potentially Preventable ED visits than their counterparts who didn't receive a PAM survey (two models: all members, BH diagnosed population), less likely to have any type of hospital admission, and/or more likely to have at least one primary care visit. The logistic model yields an Odds Ratio, which is a measure of association between an "exposure" and an "outcome". In this analysis, we consider receiving a PAM Survey under the DSRIP project to be the "exposure", while having a Potentially Preventable ED visits, hospital admission, and/or a primary care visit serves as the "outcome" (Szumilas, 2010[2]). In this example, the Odds Ratio represents the odds that a Medicaid member will experience a PPV given the member also received a PAM Survey compared to the odds of experiencing a PPV in the absence of any PAM.

The following table presents the results from the statistical regression analysis. Each row represents a regression model, with the performance metric proxy as the dependent (outcome) variable and an indicator variable for having completed a PAM survey as the independent (exposure) variable. Regression modeling yields the Odds Ratio, as explained above. An Odds Ratio[3] greater than one indicates that having received at least one PAM survey is positively associated with the outcome variable. In the case of primary care visits, a positive association is desirable. In the cases of PPVs and hospital admissions, a negative association is desirable. However, in our analysis, we find no association with primary care utilization and a positive (undesirable) association between having completed a PAM survey and potentially preventable ED visits and hospitalizations. For example, those who completed a PAM survey were 26% more likely than those who did not complete a PAM survey to have at least one potentially preventable ED visit at any point in time.

[2] Szumilas, M. (2010). Explaining odds ratios. Journal of the Canadian Academy of Child and Adolescent, 19(3), 227–229.

[3] Refer to the appendix for details on regression analysis, model used and interpreting odds ratio

Table 4: Regression Analysis Results			
Outcome Measure	**Odds Ratio**	**Interpretation**	**Score Card Points (15)**
Indicator variable for 1+ Primary Care visits	No significance	Completing a PAM survey has no significant association with visiting a Primary care physician.	0
Indicator variable for 1+ Potentially Preventable ED visits	1.261***	Completing a PAM survey is associated with 26% greater likelihood of having one or more potentially preventable ED visits.	0
Indicator variable for 1+ Potentially Preventable ED Visits – Behavioral Health	1.623***	Members with a BH diagnosis who complete a PAM survey are 62% more likely to have one/more potentially preventable ED visits.	0
Indicator variable for 1+ Inpatient Discharges	1.583***	Completing a PAM survey is associated with 58% greater likelihood of having one or more inpatient discharges.	0
		Total Points Assigned to Score Card	**10.8**
Source: CCN Team analysis using CCN project data, Salient Interactive Miner, and Medicaid Claims data from the MY5 Attributed population, July 2016 to June 2019.			

Summary of quantitative findings: These base regression models suggest a weak association between the PAM project services and the outcome variables of interest. The analysis primarily focused on a measure of care engagement (having one or more primary care visit) and found no statistically significant results: in this cross-section of Medicaid members, those who completed a PAM survey were no more likely than others to use primary care services. This analysis also considered the association between completing a PAM survey and Inpatient Admissions and Preventable ED visits (total and among Medicaid members with a behavioral health diagnosis). While the intent would be to reduce preventable ED visits and hospital admissions, this cross-sectional analysis shows a positive association. It is worth noting that a possible interpretation is a reverse-causality relationship: Medicaid members with potentially preventable ED visits and hospital stays are at an increased likelihood of completing PAM surveys, either as part of a navigational service, Health Coach service (Care Transition), another DSRIP service, or on its own. This interpretation makes sense given that PAM surveys have been completed in a variety of locations, including hospitals and in conjunction with other DSRIP project activities. Unfortunately, cross-sectional modeling cannot differentiate the direction of causality or association; this is a limitation in this type of modeling.

Qualitative Findings

I. Project Specific Feedback from Partners

CCN conducted in-depth interviews with Partners which participated in this project. The objective of the in-depth interviews was to gather feedback on the partner experience and evaluate each DSRIP project with regard to the patient outcomes, system transformation, and development of Partner capacity (skills, tools, competency) for VBP. Secondarily, the in-depth interviews were designed to capture information on the potential effect of discontinuing the project to CCN partners. Although, this impact can be separated from the program impact, it is useful information to CCN as it reflects on the funding decision impact on overall engagement with CCN, workforce changes, and system transformation.

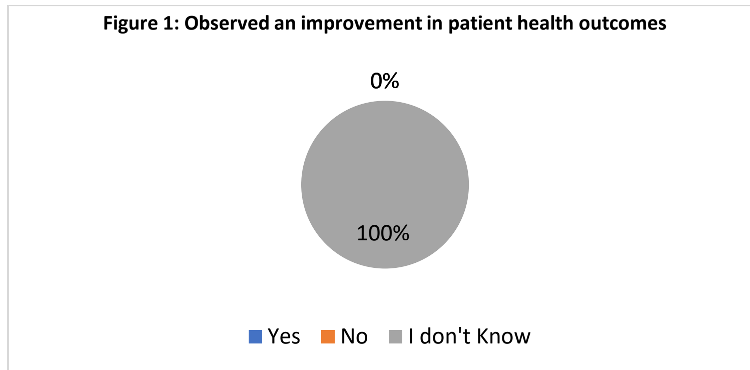
For each project, two to four individuals from participating partners were interviewed. Partners were identified for participation based on historical engagement and overall knowledge of DSRIP and the project (objectives and methods). Results have been aggregated although, in many cases, direct quotes from interviewees have been included to add context and depth to the results. The same interview tool was used for all interviewees. Interviews lasted 30 to 60 minutes.

Project Setup and History: One of the first community-based organizations began an Insignia trainers command site in April 2016. This partner reported to have found the PAM tool to be incredibly valuable. This partner reported that the PAM survey is the only evidence-based tool where they can measure not only individual progress over time, but also sub-populations and their progress overtime. Besides the community health workers are trained on how to fully utilize, not only the PAM survey but also the reports, and activation tools, which are incredibly valuable.

Patient Outcomes

Table 5: Patient Outcomes			
Interview Question	**Rating**	**Feedback**	**Score**
Extent project has made a positive impact on patients/clients	★★★★☆	Just the PAM survey is not enough. It is essential to establish a baseline and then help monitor progress overtime. Bridging the gap between clinical care and nonclinical care will lead to more patient centered focused care.	5
Extent project activities make a positive long-term impact on patients/clients	★★★☆☆	During a review of some initial PAM surveys over time to report out to clinical governance, typically you would see a 1-2-point increase in the PAM score. On average it was documented to have an average increase of 15 points with an n of about 90 to 100 patients.	3
Average			4

Figure 1: Observed an improvement in patient health outcomes? 2 out of 2 of respondents said they don't know.



Cost of Care

Table 6: Cost of Care			
Interview Question	**Rating**	**Feedback**	**Score**
Extent project activities reduction in cost of care long term	★★★★☆	More people have paid attention to insurance information. That's made a difference as it is one of the first things that is asked for and if patients don't have one, resources are provided to them via this project.	5

Figure 2*:* Lasting Partnerships
Two of the two respondents said that project 2di provided them with opportunities to partner with others and these partnerships were successful. However, Two of the two of the respondents said they would not continue these partnerships after the project concludes. One of the partners stated that only if someone pays for the license, they can continue their partnerships as without the Insignia license, they can't use the tool. They have yet to find MCO or a hospital system, or a PPS/ACO/IPA that would be willing to carry it beyond the current DSRIP contracts.

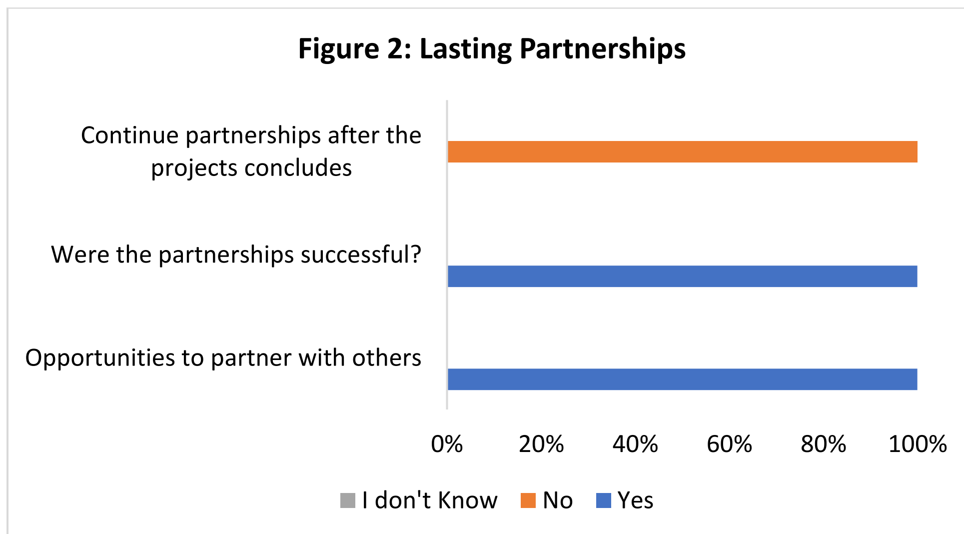


Table 7: Lasting Partnerships			
Interview Question	**Rating**	**Feedback**	**Score**
Extent the project activities have improved coordination of patient care	★★★★☆	New physicians have used it effectively and that has made a change in coordination of patient care.	5

Workforce Development

When asked about how many positions were involved in this project. One partner said 12 positions. They stated that project activities consume minimal to about half of their time. The graph below highlights the rating that respondents gave on a scale of 1 to 5 with 1 being "Not at all" and 5 being "Completely"

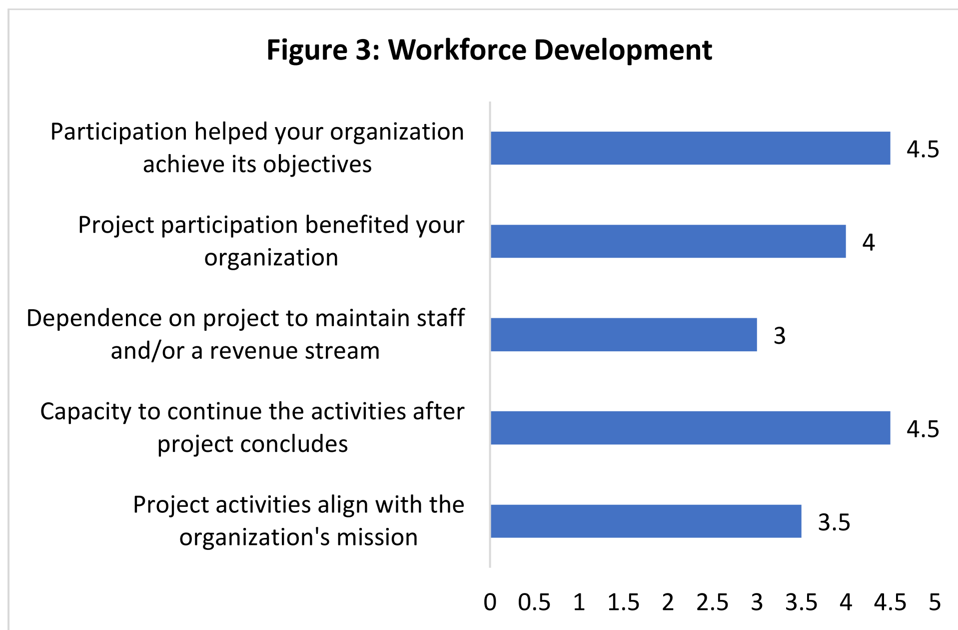


Figure 3: Workforce Development: When asked about whether the extent to which project activities align with the organization's mission, respondents gave it a rating of 3.5. Respondents said that they have the capacity to continue activities after the project concludes and gave it a rating of 4.5. When asked about the extent to which the organization depends on the project to maintain staff and/or revenue stream, the partners gave it a rating of 3.

When asked about whether the project benefitted their organization, respondents gave it a rating of 4. Similarly, when asked whether participation helped their organization achieve its objectives, they gave it a rating of 4.5.

Organization is Looking for Future Source of Funding

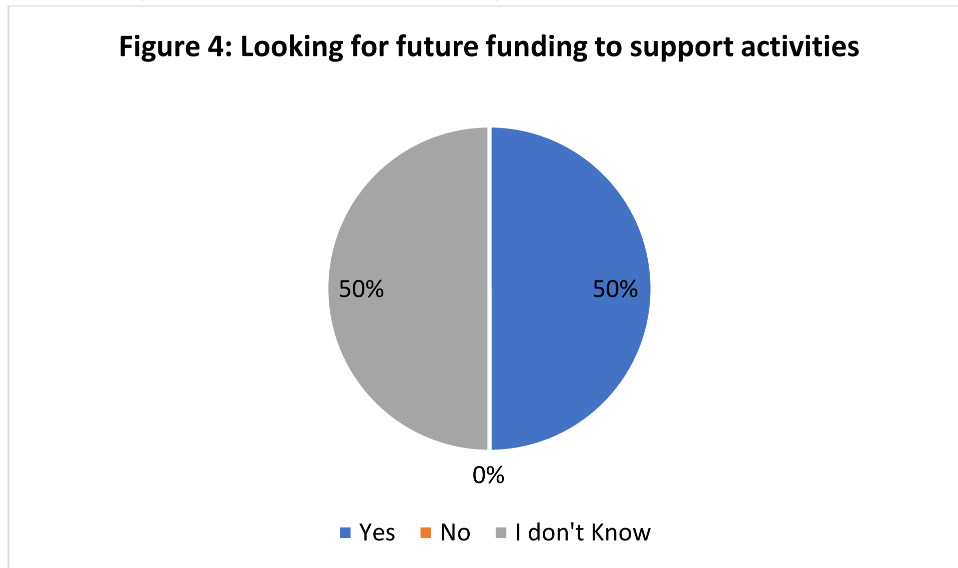


Figure 4*:* When asked about whether the partners engaged with 2di are looking for future sources of funding, one of the two respondents said yes, and one reported that they didn't know. Similarly, when asked if their staff will be downsized or redeployed if the project is discontinued, one respondent said they don't know and one said they would downsize.

New skills/competencies derived from project participation

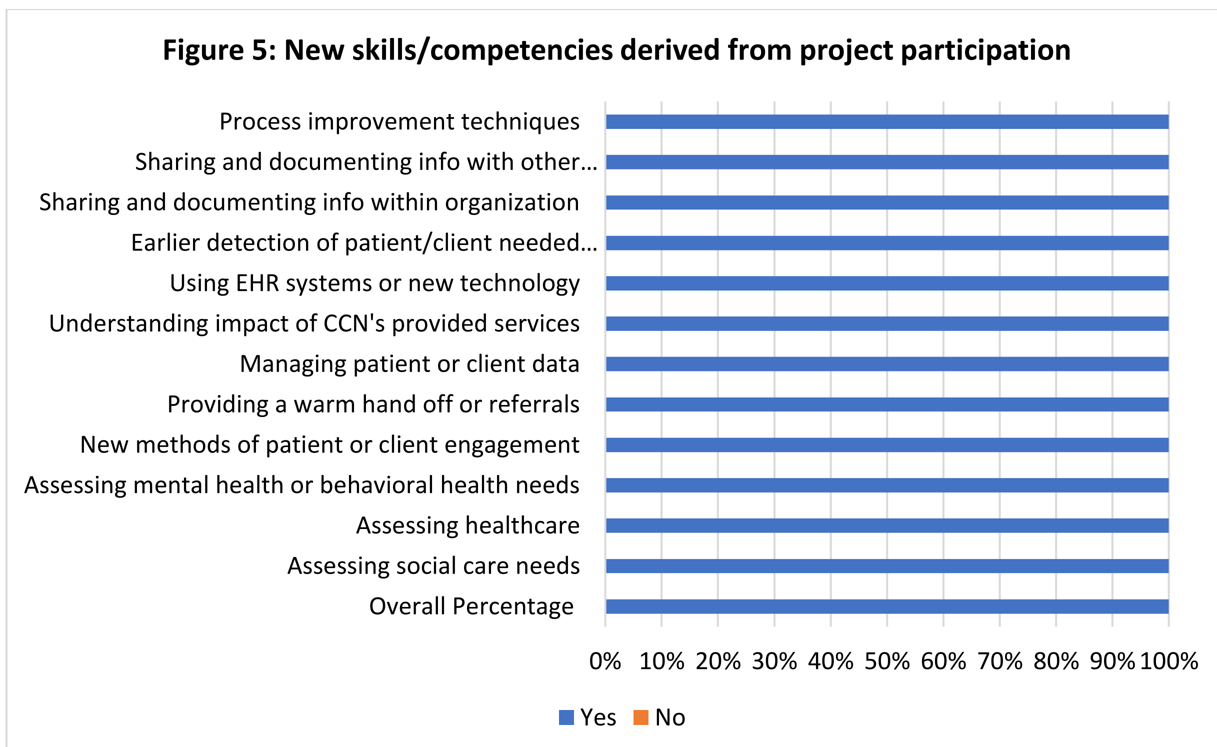


Figure 5: Two of the two respondents said that they developed the following new competencies and skills as a result of this DSRIP Project:

a. Assessing social care needs
b. Assessing healthcare
c. Assessing mental health or behavioral health needs
d. New methods of patient or client engagement
e. Providing a warm hand off or referrals
f. Managing patient or client data
g. Assessing and understanding impact of our organization's provided services
h. Earlier detection of patient/client needed resources
i. Sharing and documenting info within organization
j. Sharing and documenting info with other organizations
k. Process improvement techniques

Extent to which participation benefited the partner organizations

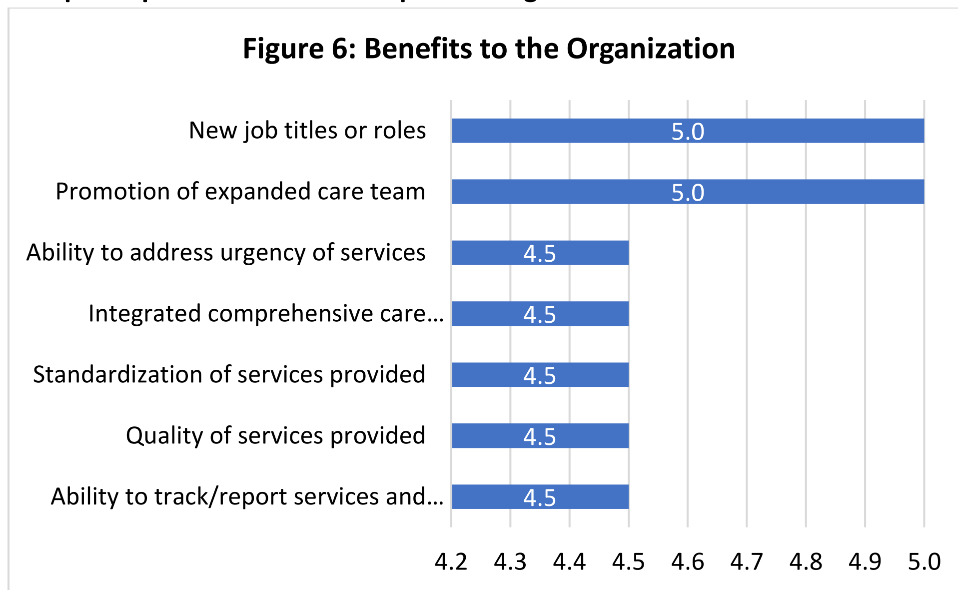


Figure 6: When asked to what extent participation in the project benefitted our partner organizations, the overall ranking ranged between 4 and 5 on a scale of 1 to 5 where 1 being "Not at all" and 5 being "Significant". In terms of ability to track and report on services/outcomes, respondents rated it a 4.5 out of 5. Regarding the quality and standardization of services provided, partners ranked it at 4.5. Integrated comprehensive care planning is rated 4.5. Ability to address urgency of services is ranked at 4.5. In terms of promotion of expanded care team and creating new job titles/roles, two respondents rated it as being "Significant"

Table 8*: Scoring of Workforce Development Questions*

Questions	Rating	Score
Project activities align with the organization's mission	★★★½☆	3.5
Capacity to continue the activities after project concludes	★★★★½	5
Project participation benefited your organization	★★★★☆	5

Participation helped your organization achieve its objectives	★★★★½	5
Ability to track/report services and outcomes	★★★★☆	5
Quality of services provided	★★★★½	5
Standardization of services provided	★★★★½	5
Integrated comprehensive care planning	★★★★½	5
Ability to address urgency of services	★★★★½	5
Promotion of expanded care team	★★★★★	5
New job titles or roles	★★★★★	5
Average		**4.86**

Finally, to conclude feedback on Workforce Development, we asked a few general questions and received a rating as highlighted in the table below. Rating of 1 is "Minimal" and 5 is "Significant".

Table 9*:* Workforce Development

Questions	Rating	Score
a. This DSRIP project has helped your organization prepare in performance-based contracts with payers.	★★★★½	5
b. This DSRIP project has helped your organization promote or develop our services.	★★★★☆	5
c. This DSRIP project provided funding for activities that were otherwise unfunded.	★★★½☆	3.5
d. This DSRIP project provided funding to train and/or expand your personnel in ways you would have not done ourselves.	★★★★½	5
e. This DSRIP project supported your organization to undertake activities that we see value in.	★★★★☆	5
f. Your organization will continue the activities of this project after the DSRIP project completes.	★★★★★	5
g. This DSRIP project has given your organization a platform to share best practices.	★★★★½	5
Average		**4.78**

System Transformation

To assess system transformation, we asked the partners number of questions and got a rating as highlighted in the table below. Rating of 1 is "Not at all" and rating of 5 is "Completely". The respondents could reply "Don't know".

Table 10*:* System Transformation

Questions	Rating	Feedback	Score
a. Better integration of services across settings or organizations	★★★½☆	Integration of services with CBOs is working well. However, there needs to be collaboration between the clinical providers and managed care organizations.	3.5
b. Ability to share data in real time to improve patient or client care	★★★★½	Although the organizations can share the PAM survey results in real time with	5

		providers, it necessarily doesn't mean that they understand it and utilize it.	
c. Promotion of community-based services (over institutional care)	★★★★☆	There isn't a better way to promote a non-clinicnal care out of community based settings than using the PAM as baseline and a measurement improvement overtime. It's the only objective, measureable tool that is simple to use.	5
d. Promotion of team-based care (more coordinated care; cross-organizational teams)	★★★★☆	The PAM is one on one individual tool and the coaching for activation is one on one intervention, but if someone would benefit from a small group, the organizations are willing to make an automatic referral for community health education	5
e. More efficient services that reduce waste in the system	★★★★☆	Even though the organizations are integrated internallly, they could still be more efficient in training more people to understand the PAM, the survey, the tool, the results, and what it means.	5
f. Implementation of self-management goals	★★★★☆	It gives you not just that short term and long term goal, but it gives you those action steps.	5
g. Shift in staff mindset in addressing patient needs	★★★★⯪	It changes the mindset of all the staff that come into an organization, especially the community health workers, and once they are trained in the model and use the coaching for activation tools, it changes the delivery of care.	5
h. New billable service development	★★★★☆	Our partners are still looking for those opportunities with the MCO or the larger safety net providers, like the hospital systems.	5
Average			**4.81**

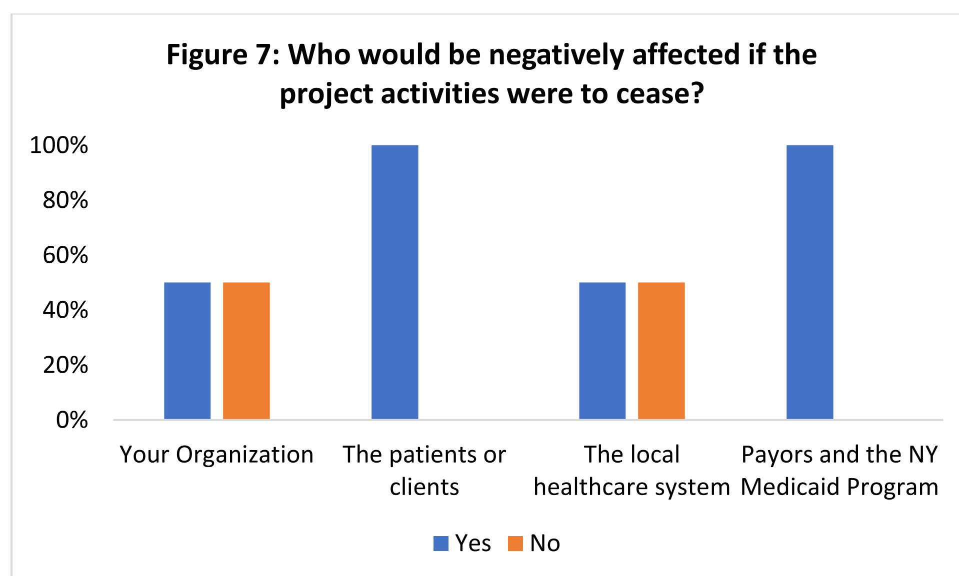


Figure 7: When asked who would be negatively affected if the DSRIP project was to cease – one respondent reported their organization and the local healthcare system would be impacted. Both respondents said that their patients/clients and the payors/NY Medicaid program would be impacted.

II. Project Specific Feedback from Project Managers

Milestone Rating and Feedback: Success on key milestones of this project have been evaluated by Project Manager at CCN in an in-depth interview:

Table 11: System Transformation

Milestone	Rating	Success Factors	Gaps	Score(10)
Establish a PPS-wide training team of PAM experience and expertise in patient activation and engagement	★★★★★	The use of a "train the trainer" model helped CBO' to rapidly develop PAM competencies. Master trainers helped to coordinate effective outreach and trainings. Adopting a rule that PAM surveys could not be submitted until complete also contributed to the success of this milestone.	Difficulty with scheduling trainings.	10
Measure key components of the PAM survey such as patient status and contact information when patient visits PPS designated facility.	★★★★☆	Pre-screening tools helped identify the right population to engage in the program. Eventually removing low/non-utilizers identification from the survey allowed more surveys to be completed.	Originally defining a low/non-utilizer population through the pre-screening was too restrictive. The steps required to adopt and record this screen was cumbersome and duplicative for some agencies.	10
Increase the volume of non-emergent care provided to patients.	★★☆☆☆	Failed to meet DOH State outcome but generate productive discussion at PAC executive around patient volume in preventative care. Ex: helped identify gaps in dental care.	Primary care, dental care, and behavioral health did not implement this project and cold-calling potential clients was ineffective.	2
Partner with CBOs to develop group of community navigators trained in connectivity to community health care resources and patient education.	★★★★★	There was an organic relationship between the PAM and Care Transitions projects; patients would complete a PAM survey and then receive immediate and consistent follow-up from community navigators.	Sometimes there was a lack of connection with community providers, although not a consistent issue.	10
Partner with CBOs to develop group of community navigators trained in connectivity to community health care resources and patient education.	★★★★★	There was an organic relationship between the PAM and Care Transitions projects; patients would complete a PAM survey and then receive immediate and consistent follow-up from community navigators.	Sometimes there was a lack of connection with community providers, although not a consistent issue.	10
Ensure hand-off to navigators who are prominently stationed at community "hot-spots", CBO's, ED's, or community events.	★★★★★	Direct handoffs to navigators doing the PAM survey, ensuring uninsured patients obtained coverage, conducting PAM surveys in free clinics to captures	There were some gaps in the handoff methodology. Namely, once the navigator captures the community need, there	10

		uninsured patients, and continued follow-up with uninsured patients all contribute to the success of this milestone.	was some uncertainly in connecting them to services.	
Average				**8.66**

Overall DSRIP Gaps in Care going forward

There remains an ongoing need to establish a PPS-wide referral tool that allows providers to share data and track patients across all systems. Without a truly comprehensive referral tool, there continues to gaps in measures and key patient information across the continuum of care. To effectively begin to close this gap, 2di would have to better integrate into Primary Care, Emergency Rooms, and Dental Practices since these providers largely did not participate in the CCN DSRIP 1.0 2di project due to the cumbersomeness of an added screening tool.

Importance in improving SDOH outcomes (1.5)

CCN PMO rated Project 2di as a "low-medium impact" project. This rating was given because of the difficulty with implementing this project PSS-wide, thus producing gaps in measures and overall effectiveness of the project, which was intended to be implemented PPS wide. However, despite these barriers, 2di is impactful to SDOH outcomes because of the way it improved cross sector partnerships.

Qualitative Measures

Table 12*:* Qualitative Measures

Measure	Rating	Feedback	Score (6)
Patient activation helped patients in better understanding of their health and self-management of disease, thus reducing inpatient admissions	★★★☆☆	• Patient navigation helped some patients understand, but not all • Understanding by patients was not necessarily an objective of the training/project • Most of the training was on how to implement motivational interviewing, rather than making use of the "flourish" tool in Insignia • There hasn't been an official report that says the PAM survey reduces hospital admissions	4

III. Regional Performing Unit Feedback

During the month of May we collected survey responses from all participants at RPU Meetings on two topics: Workforce development and System Transformation. The survey was rating based from 1 to 5 with 1 being "Minimal" and 5 being "Significant". We received 38 responses in total. The table below highlights the distribution of responses across the RPU's. Approximately 5.26% (2 responses out of 38) of the responses was for project 2di

Table 13: RPU Responses			2di
South	47.37%	18	1
North	34.21%	13	1
West	10.53%	4	0
East	7.89%	3	0
Total	100.00%	38	2

Table 14: Scoring of Workforce Development Questions

Questions	Rating	Score(5)
Ability to track/report services and outcomes		3
Quality of services provided		5
Standardization of services provided		3
Integrated comprehensive care planning		3
Ability to address urgency of services		5
Promotion of expanded care team		3
New job titles or roles		3
Average		**3.57**

Table 15: Workforce Development

Questions	Rating	Score(5)
a. This DSRIP project has helped your organization prepare in performance-based contracts with payers.		5
b. This DSRIP project has helped your organization promote or develop our services.		3
c. This DSRIP project provided funding for activities that were otherwise unfunded.		5
d. This DSRIP project provided funding to train and/or expand your personnel in ways you would have not done ourselves.		3
e. This DSRIP project supported your organization to undertake activities that we see value in.		3
f. This DSRIP project has given your organization a platform to share best practices.		3
Average		**3.66**

Table 16: System Transformation

To assess system transformation, we asked the partners number of questions and got a rating as highlighted in the table below. Rating of 1 is "Not at all" and rating of 5 is "Completely". The respondents could reply "Don't know".

Questions	Rating	Score(5)
a. Better integration of services across settings or organizations		5
b. Ability to share data in real time to improve patient or client care		3
c. Promotion of community-based services (over institutional care)		5
d. Promotion of team-based care (more coordinated care; cross-organizational teams)		5
e. More efficient services that reduce waste in the system		5
f. Shift in staff mindset in addressing patient needs		5
g. New billable service development		1
Average		**4.14**

Appendix

Detailed Scoring Matrix

Scoring Matrix		
Key Elements	**Description**	**Points**
Quantitative Analysis	**Data from Projects and Salient**	**25 points**
1. Regression Analysis	**Statistical Association between Key activities undertaken during specific projects and HEDIS measures**	**15 points**
a) Key HEDIS Measures	Statistical Association between 0 and 50%	8 points
b) Key HEDIS Measures	Statistical Association between 51% and 75%	12 points
c) Key HEDIS Measures	Statistical Association between 76% and 100%	15 points
d) Causal Effect	**Negative association of project activity with ER Visits (2 pts)** **Negative association of project activity with Hospitalizations (2 pts)** **Positive association between project activity and Primary Care (2pts)**	**6 Points**
e) Cost Effectiveness Analysis	**Costs averted due to reduction in ED visits (1.3 pts)** **Costs averted due to reduction in Hospitalizations (1.3pts)** **Costs spent due to increase in PC Visits (1.3pts)**	**4 Points**
Qualitative Analysis	**Assessments conducted with various stakeholders involved in Speed and Scale Projects**	**75 Points**
2. Project Specific Feedback from Partners	**Interviews conducted by RMS with select partners for speed and scale projects**	**25 points**
a) Patient Outcomes	Scale of 1 to 5 - 4 and above	**5 points**
	Scale of 1 to 5 - score of 3	3 points
	Scale of 1 to 5 - score of 2 or 1	1 point
b) Cost of Care	Scale of 1 to 5 - 4 and above	**5 points**
	Scale of 1 to 5 - score of 3	3 points
	Scale of 1 to 5 - score of 2 or 1	1 point
c) Lasting Partnerships	Scale of 1 to 5 - 4 and above	**5 points**
	Scale of 1 to 5 - score of 3	3 points
	Scale of 1 to 5 - score of 2 or 1	1 point
d) Workforce Development	Scale of 1 to 5 - 4 and above	**5 points**
	Scale of 1 to 5 - score of 3	3 points
	Scale of 1 to 5 - score of 2 or 1	1 point
e) System Transformation	Scale of 1 to 5 - 4 and above	**5 points**
	Scale of 1 to 5 - score of 3	3 points
	Scale of 1 to 5 - score of 2 or 1	1 point
3. Project Specific Feedback from Project Managers	**Interviews conducted by Population Health Team with project managers for speed and scale projects**	**25 points**
a) Milestones Ratings	Scale of 1 to 5 - 4 and above	**10 points**
	Scale of 1 to 5 - score of 3	7 points

	Scale of 1 to 5 - score of 2 or 1	2 point
b) Successes specific to Milestones	Qualitative statements	**1.5 points**
c) Gaps specific to Milestones	Qualitative statements	**None**
d) Overall DSRIP Gaps in care going forward	Qualitative statements	**None**
e) Importance in improving SDoH outcomes	Qualitative statements	**1.5 points**
f) Qualitative Questions	Scale of 1 to 5 - 4 and above	**6 points**
	Scale of 1 to 5 - score of 3	4 points
	Scale of 1 to 5 - score of 2 or 1	2 point
g) Opportunities for Improvement	Scale of 1 to 5 - 4 and above	**6 points**
	Scale of 1 to 5 - score of 3	4 points
	Scale of 1 to 5 - score of 2 or 1	2 point
4. Member Panel Feedback from Patients	**Survey conducted by RMS with Member Panel regarding Speed and Scale Project**	**15 points**
a) Were asked about their health during visit	> 90% responded yes	**5 points**
	Between 75 to 89%	3 points
	Between 60 to 74%	1 point
b) Positive Experience	> 90% responded yes	**5 points**
	Between 75 to 89%	3 points
	Between 60 to 74%	1 point
c) Patient believes services provided were crucial for their well-being	> 90% responded yes	**5 points**
	Between 75 to 89%	3 points
	Between 60 to 74%	1 point
5. Regional Performing Units Feedback overall DSRIP activities	**Survey conducted by Population Health Team during RPU Meetings in May**	**10 points**
a) Workforce Development	Scale of 1 to 5 - 4 and above	**5 points**
	Scale of 1 to 5 - score of 3	3 points
	Scale of 1 to 5 - score of 2 or 1	1 point
b) System Transformation	Scale of 1 to 5 - 4 and above	**5 points**
	Scale of 1 to 5 - score of 3	3 points
	Scale of 1 to 5 - score of 2 or 1	1 point

Definitions – Statistical Associations
Direct NT: Direct Near Term - Project has a specific component (paid activity specifically) that affects the numerator of the measure in the near term (immediate impact; activity is incentivized).

Direct LT: Direct Long Term - Project has a component which encourages activities which affect the numerator of the measure. Activities may not have an immediate impact, but could encourage different future choices by members.

Mixed Direct: Project has a component which encourages activities which affect the numerator of the measure in general. Activity may not be paid; thus, although the project supports those activities, they are not specifically incentivized.

Quantitative Findings – Model Used
Regression Analysis Basics:

- The regression equation describes the relationship between the dependent variable (y) and the independent variable (x).

  $y=bx+a$

  Example: Anti-Dep Rx Fill = b_1(3ai BH screen) +b_i(Control vars$_i$)+ a

- The intercept, or "a," is the value of y (dependent variable) if the value of x (independent variable) is zero, and is referred to as the 'constant.'

- The regression results report the coefficient b that represents how a unit increase in x affect the likelihood of y, holding all other factors constant

- P value is also reported in the regression results. It shows whether the coefficient has statistically significant impact on the dependent variable or not. If the p value is 0.05, we are 95% confident that the independent variable has some effect on the dependent variable.

Model Used

Logistic regression

- Assumption: dependent variable is dichotomous and binary; in other words, coded as 0 and +1.

- We use the logit model that displays the odds ratio obtained by running the regression.

- The odds ratio is a way of comparing whether the probability of a certain event is the same for two groups.

- An odds ratio of 1 implies that the event is equally likely in both groups. An odds ratio greater than one implies that the event is more likely in the first group. An odds ratio less than one implies that the event is less likely in the first group.