2019

Delivery System Reform Incentive Payment (DSRIP) Program

Independent Evaluation
Annual Performing Provider System (PPS) Report for **Bronx Partners for Healthy Communities PPS**

DSRIP Demonstration Year 0 – DSRIP Year 4

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Overview of Report

The objective of this report is to share interim results of the New York State Delivery System Reform Incentive Payment (NYS DSRIP) program evaluation with the Performing Provider System (PPS) to inform implementation, operations, and quality improvement efforts. This report is focused on the Bronx Partners for Healthy Communities PPS. Assessments of the implementation, operation, and patient care as shared by the study participants of the Bronx Partners for Healthy Communities PPS will be reflected in this report and within the soon to be released 2019 Statewide Annual Report. These findings will be supported by representative quotations and descriptive statistics.

This is the second annual PPS report based on the independent evaluation of the NYS DSRIP program. Last year's 2018 PPS Annual Report provided results from the first research cycle conducted by the Independent Evaluator which examined early years of DSRIP program implementation and process. This 2019 report includes results from the first and second research cycles and covers the period from Demonstration Year 0 through half of Demonstration Year 4. **It does not include specific PPS analyses of administrative performance data because the DSRIP data available on performance measures was limited during research cycle 2.** However, readers should reference the soon to be released 2019 Statewide Annual Report by the Independent Evaluator which includes a preliminary analysis of available performance measures. Next year's 2020 PPS report will include results from the third research cycle of the implementation and process study and analyses of performance data.

Data sources for this 2019 report include PPS key informant interviews, partner surveys of health care providers, and patient surveys. For the Bronx Partners for Healthy Communities PPS and other New York City and Long Island based PPS, partner focus groups were also included in research cycle 2. Because of PPS partner overlap in New York City and Long Island, partner focus group findings are presented in the soon to be released 2019 Statewide Annual Report and combined with findings and context from the research cycle 1 focus groups held in the Capital District and Adirondack PPS areas.

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. Bronx Partners for Healthy Communities

3. Bronx Partners for Healthy Communities PPS Brief Overview
4. Bronx Partners for Healthy Communities PPS Findings
5. Recommendations for Bronx Partners for Healthy Communities PPS
6. Conclusion and Plans for Future Research

Section I.
Background Information

1. STATEWIDE EVALUATION APPROACH

1.a. 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:

- 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;
- Obtain information on the effectiveness of specific projects and strategies selected by the PPS and the factors associated with program success; and
- Obtain feedback from stakeholders, including New York State Department of Health (NYS DOH) staff, PPS administrators and providers, and Medicaid members served under the DSRIP program regarding the program's planning and implementation, 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. Implementation and process evaluation

The implementation and process component of the evaluation provides context regarding the health care infrastructure existing prior to the DSRIP program, process factors (e.g., communication, leadership) that shaped each PPS, and program implementation and operations 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); and
- 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.c. Time series evaluation

The statewide impact of the DSRIP program is being evaluated using an interrupted time series design to examine trends in the DSRIP domain-specific performance measures used for PPS valuation and payment. 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. The data source for the time series analysis is the DSRIP Dataset, an administrative dataset prepared by the NYS DOH for the purpose of the DSRIP program and made available to the Independent Evaluator. The DSRIP Dataset contains information on DSRIP performance measures and PPS characteristics, such as PPS member attribution, provider networks, project selection, and project service area.

1.d. Comparative analysis

The comparative analysis applies quantitative techniques to assess relative PPS performance on domain-specific metrics over time also using the DSRIP Dataset. Specifically, the comparative analysis examines how PPS characteristics are associated with changes in performance overall, and whether PPS with different characteristics have divergent changes after the initiation of the DSRIP program. The qualitative data emanating from the implementation study will be used to further contextualize the findings of both the time series analysis and the comparative analysis.

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

Exhibit 1 summarizes the data sources in the PPS-specific reports from the first two research cycles. The last row shows the final sample sizes for the Bronx Partners for Healthy Communities PPS. Following the exhibit are further details about the methods used to collect these data.

Exhibit 1. Data Sources for the PPS Annual Report

	PPS Key Informant Interviews	Statewide Partner Survey	Patient Survey (Clinician & Group CAHPS Survey version 3.0)	Regional Partner Focus Groups
What	Semi-structured telephone interviews to collect information on PPS organizational development (cycle 1), project implementation (cycle 2), and perceived performance (cycles 1 and 2).	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 and services.	In-person focus groups of project-associated partners to collect information on their perceptions of the DSRIP program.
Who	Cycle1: 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. Cycle 2: PPS administrators and staff directly responsible for launching and overseeing project implementation in Demonstration Years 0-4.	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 provider in the PPS network.	Cycle 1: Partners engaged in PPS projects from the Capital District and Adirondack regions. Cycle 2: Partners engaged in PPS projects from the New York City and Long Island areas.
When	Cycle 1: July – August 2017 Cycle 2: June – August 2018	Cycle 1: September – November 2017 Cycle2: September – October 2018	Demonstration Year 1: September 2015 – December 2015 Demonstration Year 2: September 2016 – November 2016 Demonstration Year 3: September 2017 – December 2017	Cycle 1: November 2017 Cycle 2: August 2018
Final Sample Size at Bronx Partners for Healthy Communities	**Cycle 1: 5** **Cycle 2: 13**	**Cycle 1: 23 (response rate not available; see note below)** **Cycle 2: 50 (response rate not available; see note below)**	**Demonstration Year 1: 351 (response rate of 24%)** **Demonstration Year 2: 283 (response rate of 24%)** **Demonstration Year 3: 346 (response rate of 25%)**	**Cycle 1: n/a** **Cycle 2: 11**

Abbreviations: Demonstration Year (DY), Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Notes: In the Bronx Partners for Healthy Communities PPS the survey was sent to 12 email addresses and 23 responses were received in research cycle 1. The survey was sent to 39 email addresses and 50 responses were received in research cycle 2. Because the survey was forwarded to additional people, and because partners who were not included in this PPS's list of engaged partners may have received a survey due to their engagement with another PPS, it is not possible to calculate a response rate for the Bronx Partners for Healthy Communities PPS in either research cycle.

2.a. Key informant interviews

Two cycles of key informant interviews with PPS administrators and staff have been conducted by the Independent Evaluator, using purposive sampling to identify key informants at each of the 25 PPS (Bryman 2012; Creswell 2013; Patton, 2002). During the first cycle, interviews were conducted from July through August 2017 with PPS administrators and staff identified at each of the 25 PPS who were most knowledgeable about PPS formation and structural configurations, DSRIP program start-up, implementation, ongoing processes, administrative components, and challenges in the first two DSRIP program years. If a single person did not possess the necessary knowledge and background in these areas, additional people were included in the interview. Generally, in the first cycle 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

During the second cycle, interviews were conducted from June through August 2018 with individuals who were directly responsible for launching DSRIP projects and overseeing project implementation. These were typically project managers during the implementation phase. By Demonstration Year 4, most PPS had restructured, and many project managers were phased out. Thus, the key informants for the second cycle had a variety of titles.

The interviews for both cycles were guided by an overarching interview protocol that was designed to address the following topics in both cycle:

- Early operations
- Challenges and successes
- Perceived outcomes and recommendations

Development of the interview guide for both cycles 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 New York State Department of Health. Prior to each interview, the interview guide was tailored to individual roles and PPS organizations once participants were identified. For example, for the second research cycle 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. Prior to each interview, the interviewers prepared by reviewing publicly available documents such as PPS Quarterly Reports and the Mid-Point Assessment Reports to understand the context of each PPS. For the second research cycle, the key informants received a pre-interview survey. These brief surveys collected information about each participant's role in project implementation to help prepare evaluation staff for the interview.

Interviews were conducted by telephone, with at least two interviewers participating in each interview to improve reliability. Interviews were recorded and subsequently transcribed by one of the researchers. The interviewers supplemented the audio files with hand-written notes. Finally, the interviews were organized into major themes and coded.

Interviews were conducted with five key informants from Bronx Partners for Healthy Communities in the first research cycle and thirteen key informants in the second research cycle. To ensure participant confidentiality interview findings are not included in this report, but de-identified quotes will be included in the soon to be released 2019 Statewide Annual Report.

See Appendix 1 for the Key Informant Interview Guides.

2.b. Statewide partner survey

To gather uniform information about perceptions of the DSRIP program and the functioning of individual projects, an electronic survey was administered to project-associated providers. To identify respondents in the first survey cycle, the

evaluation team built unique contact lists of providers for each of the 25 PPS by merging provider network lists from the Provider Export/Import Tool (PIT)/Provider Export/Import Tool-Revised (PIT-R) with corresponding contact information from the Medicaid Analytics Performance Portal (MAPP). The list reflected PPS networks in Demonstration Year 2. 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 who were 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.

A similar approach was used to identify respondents in the second survey cycle. A new list of partners, based on PPS networks in Demonstration Year 3, was obtained from the NYS DOH's vendor that manages the Medicaid Data Warehouse and houses the PPS updated network lists. The new lists were compared to the lists used in the first survey cycle to identify any new providers. Each PPS was asked to review the updated list that included engaged partners identified the previous year as well as new providers, identify additional engaged partners that were not yet on the list, and indicate if any partners were no longer engaged.

The survey questions in each cycle 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
- Overall perception of the DSRIP program
- Overall perception of DSRIP projects
- Preparations for value based payment

Most survey items were kept consistent across cycles to allow for interpretation of changes over time. Some questions were modified in the second cycle, based on feedback from the first cycle and emerging topics. Changes included adjusted time frames, dropping questions about early implementation, and adding items about the specific resources needed to transition to value based payment.

For the first cycle, the survey launched in September 2017 on the Qualtrics online survey platform and closed in November 2017. In the Bronx Partners for Healthy Communities PPS, the survey was sent to 12 email addresses and 23 responses were received. For the second cycle, the survey launched in September 2018 and closed in October 2018. The survey was sent to 39 valid email addresses and 50 responses were received from the Bronx Partners for Healthy Communities PPS. Because the survey was forwarded to additional people, and because partners who were not included in this PPS's list of engaged partners may have received a survey due to their engagement with another PPS, it is not possible to calculate a response rate for the Bronx Partners for Healthy Communities PPS in either research cycle.

For this report, Partner Survey data were cleaned by the evaluation team and then analyzed using SPSS software for respondent characteristics and respondent perceptions of project evaluations, DSRIP benefits, benefits by project type, benefits by organization type, value based payment, and DSRIP effectiveness.

Quantitative and qualitative results from the Partner Survey are included in this report. Representative quotes received from respondents to the Independent Evaluator's 2017 and 2018 Partner Survey were minimally edited for clarity, but not for grammar.

See Appendices 2 and 3 for further details about Partner Survey methodology and copies of the instruments.

2.c. Focus groups

The Independent Evaluator is conducting a series of regional focus groups with project-associated partners to yield information about how the DSRIP program and its system transformation outcomes are affecting partners

In the second research cycle, 12 focus groups were conducted in August 2018 with project-associated partners in New York City and Long Island. Engaged partners were identified using the same methodology as the Partner Survey, described above and were contacted and invited to participate. Because focus groups function best when groups are somewhat homogeneous (Stewart and Shamdasani, 2015), the focus groups were split into four provider categories.

- **Group 1:** Primary care physicians (PCPs), clinic managers, health home organizations, and specialists;
- **Group 2**: Mental health and substance use professionals;
- **Group 3**: Hospitals, nursing home, hospice, and home care professionals; and
- **Group 4:** Community-based organization professionals.

Focus groups lasted approximately 1.5 hours. A meal was provided for each focus group to convey appreciation for the participants' time. Focus group recordings were transcribed, coded, and analyzed for patterns and themes.
Eleven partners from the Bronx Partners for Healthy Communities PPS participated in the focus groups. Because several focus group participants were associated with multiple PPS in the New York City and Long Island areas, individual quotes cannot be attributed to specific PPS and are therefore not included in this report. However, aggregated findings from research cycle 2 focus groups are included in the soon to be released 2019 Statewide Annual Report.
The focus group guide is available in Appendix 4.

2.d. Patient survey (CAHPS survey)

Patient perspectives were assessed via the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) (version 3.0) survey, administered annually by DataStat, Inc. The CG-CAHPS (version 3.0) survey is 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 provider in the PPS network from January to June prior to the survey administration. Each year's survey targeted 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, with a phone call follow-up to non-responders).

The CG-CAHPS data presented in this report were collected in Demonstration Years 1, 2, and 3. The Demonstration Year 1 survey was conducted between September 14, 2015 and December 7, 2015. In the Bronx Partners for Healthy Communities PPS, a total of 351 responses were received resulting in a 24% response rate (after excluding ineligible participants). The Demonstration Year 2 survey was conducted between September 16, 2016 and November 30, 2016. A total of 283 responses were received in Demonstration Year 2, resulting in a 24% response rate. The Demonstration Year 3 survey was conducted between September 18, 2017 and December 3, 2017. A total of 346 responses were received in Demonstration Year 3, resulting in a 25% response rate.

Section II.
Bronx Partners for Healthy Communities PPS

3. BRONX PARTNERS FOR HEALTHY COMMUNITIES PPS BRIEF OVERVIEW

Readers are encouraged to refer to Section 3 of the 2018 Bronx Partners for Healthy Communities Annual PPS Report for a brief general overview of DSRIP PPS, as well as the attribution, valuation, and project selection information for the Bronx Partners for Healthy Communities.

4. BRONX PARTNERS FOR HEALTHY COMMUNITIES PPS FINDINGS

Bronx Partners for Healthy Communities' network comprises more than 230 Bronx-based organizations including two hospitals, Federally Qualified Health Centers, long-term care and developmental disability providers, health homes, substance use treatment agencies, and community-based organizations. The mission of Bronx Partners for Healthy Communities PPS is to improve the health and wellness of the Bronx community and implement innovative community-level projects which transform the system of clinical delivery.[1]

This report contains interwoven data findings from data collected in the Bronx Partners for Healthy Communities partner survey and patient survey during research cycles 1 and 2. As noted in Section 2, representative quotes from the Key Informant Interviews and Focus Group Discussions are not included in this report, but are included in the soon to be released 2019 Statewide Annual Report.[2] This report highlights both the successes and challenges faced by participants in the implementation and operation of the DSRIP program. In both data collection periods, special attention was taken to collect retrospective data, as well as current implementation and process data up to the time period concurrent with the data collection. Thus, research cycle 1 findings reflect Demonstration Year 0 up to the first half of Demonstration Year 3 while research cycle 2 findings reflect Demonstration Year 0 up to the first half of Demonstration Year 4. Findings are organized into six sections:

a) Bronx Partners for Healthy Communities partner perceived effectiveness of the DSRIP program

b) Bronx Partners for Healthy Communities partner perceived benefits and changes due to the DSRIP program

c) Bronx Partners for Healthy Communities partner perceived effectiveness of and satisfaction with projects

d) Bronx Partners for Healthy Communities partner perceptions of value based payment readiness

e) Bronx Partners for Healthy Communities patient perceptions of care

f) Bronx Partners for Healthy Communities partner DSRIP program improvement recommendations

g) Bronx Partners for Healthy Communities partner focus group aggregated responses within the soon to be released 2019 Statewide Annual Report

[1] This information was obtained from the PPS website, http://www.bronxphc.org/

[2] Key informant interview findings are not included in this report in order to ensure participant confidentiality. Because several focus group participants were associated with multiple PPS in the New York City and Long Island areas, individual quotes cannot be attributed to specific PPS and are therefore not included in this report.

4.a. Bronx Partners for Healthy Communities partner perceived effectiveness of the DSRIP program

Most partner survey respondents (86% in 2017; 64% in 2018) reported the DSRIP program to be at least moderately effective (Exhibit 2). This was slightly lower than the statewide percentage in 2018. The number of Bronx Partners for Healthy Communities partners responding to the survey increased from 23 in 2017 to 50 in 2018.[3]

Exhibit 2. How effective do you perceive DSRIP to be overall?

	2017		2018	
	BPHC (N=21)	NYS (N=764)	BPHC (N=49)	NYS (N=942)
Extremely effective	24%	9%	2%	9%
Very effective	14%	25%	25%	25%
Moderately effective	48%	40%	37%	36%
Slightly effective	14%	20%	31%	23%
Not at all effective	0%	5%	6%	7%

Source: Authors' analysis of the 2017 and 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Note: Percentages do not total 100% due to rounding

About three-quarters of respondents (72% in 2017; 79% in 2018) believed that DSRIP programs positively affected population health in their service area (Exhibit 3).

Exhibit 3. Do you believe DSRIP has changed any aspect of population health within your service area?

	2017		2018	
	BPHC (N=21)	NYS (N=771)	BPHC (N=48)	NYS (N=946)
Very positive change	24%	8%	4%	14%
Some positive change	48%	47%	75%	60%
No change	14%	23%	15%	18%
Some negative change	0%	<1%	0%	<1%
Very negative change	0%	0%	4%	<1%
I don't know	14%	22%	2%	8%

Source: Authors' analysis of the 2017 and 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Notes: The 2018 Statewide Annual Report did not include the "No change" response in analysis of this item. Percentages do not total 100% due to rounding

More than three-fourths of survey respondents (81% in 2017; 86% in 2018) said that patients were experiencing positive change in care (Exhibit 4). These percentages were higher than those statewide.

[3] Responses to individual survey items may have been less than 23 or 50 in 2017 and 2018, respectively.

Exhibit 4. In your view, are patients experiencing better care since the launch of DSRIP?

	2017		2018	
	BPHC (N=21)	NYS (N=772)	BPHC (N=50)	NYS (N=952)
Very positive change	14%	9%	8%	15%
Some positive change	67%	54%	78%	60%
No change	0%	18%	8%	14%
Some negative change	5%	<1%	0%	1%
Very negative change	0%	0%	2%	<1%
I don't know	14%	19%	4%	9%

Source: Authors' analysis of the 2017 and 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Notes: The 2018 Statewide Annual Report did not include the "No change" or "I don't know" responses in analysis of this item. Percentages do not total 100% due to rounding.

Partner survey respondents praised the DSRIP program for its improvements to patient care.

> *We have found the relationship with BPHC to be very satisfying and focused on improving patient care. It has allowed us to provide health and behavioral health related screening, assessment, education and linkage to care for a population that has been disconnected from the healthcare system thus far, and given us the resources to try innovative ways of becoming more effective.* ***– 2018 partner survey respondent***

> *Thank you for the ability to participate on the DSRIP projects. The programs were inclusive, effective and collaborative. The relationships created by DSRIP will be sustainable long after the program ends.*
> ***– 2018 partner survey respondent***

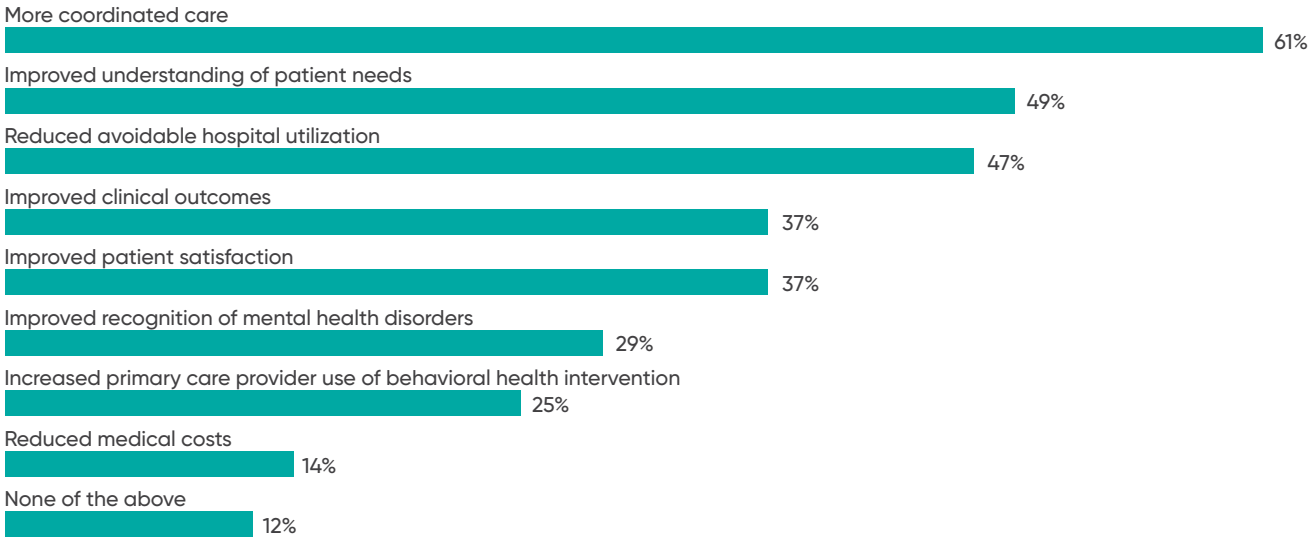
> *DSRIP has allowed us to fund programs that helped improve patient care and patient outcomes.*
> ***– 2018 partner survey respondent***

4.b. Bronx Partners for Healthy Communities partner perceived benefits and changes due to the DSRIP program

Survey participants were asked if they observed any of the following benefits from the DSRIP program (Exhibit 5). In 2018, 61% perceived more coordinated care, and about half saw improved understanding of patient needs and reduced avoidable hospital utilization. Over one-third saw improved clinical outcomes and improved patient satisfaction.

A similar item in the 2017 survey generated similar responses (data not shown). However, in 2018, more partners observed reduced avoidable hospital utilization and improved clinical outcomes.

Exhibit 5. Benefits attributed to DSRIP program (N=49)

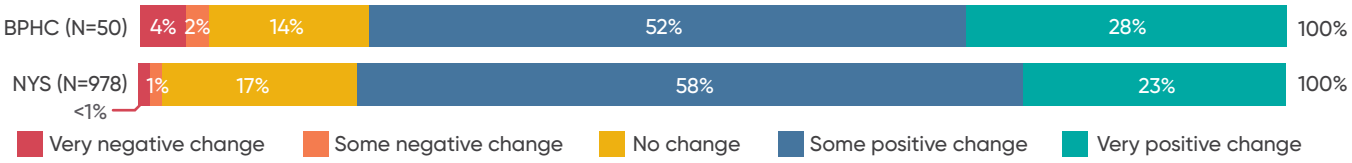


Source: Authors' analysis of the 2018 statewide partner survey.
Note: Percentages do not total 100% because respondents could select more than one item.

In 2018, respondents who selected each benefit were asked whether they expected that benefit to continue after DSRIP program funding ended. Of these, at least 61% of respondents believed that each of the benefits would continue.

In the 2018 partner survey, 80% of respondents reported that the services or clinical care at their organization had changed for the better since the DSRIP program was initiated (Exhibit 6).[4]

Exhibit 6. How have the services or clinical care at your organization changed since DSRIP was initiated?



Source: Authors' analysis of the 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Note: Percentages do not total 100% due to rounding.

Partner survey participants noted a number of changes due to the DSRIP program in their open-ended responses, including better communication, increased referrals to behavioral health services, and improvements in their ability to use and analyze patient data. They also saw greater emphasis on and appreciation of the social determinants of health.

> DSRIP has provided a pathway for improved communication with hospitals. Concerted efforts are underway to coordinate care to avoid unnecessary hospitalizations. DSRIP has put us on the right path for improved outcomes and reduced costs. *– 2018 partner survey respondent*

> Promoting an understanding and appreciation of the social determinants of health by the medical community. Also, I see better electronic communication between providers and increased ability to analyze and use patient data. *– 2018 partner survey respondent*

[4] Direct comparison to the 2017 Statewide Partner Survey is not possible for this survey item due to wording changes to improve clarity.

> Communication and referrals between physical health providers and behavioral health providers has greatly improved. More awareness among physical health providers of the availability of services. Pathways for referrals have been established and/or streamlined. *– 2018 partner survey respondent*

4.c. Bronx Partners for Healthy Communities partner perceived effectiveness of and satisfaction with projects

The partner survey asked providers about their experiences with individual projects as well as their experiences with the DSRIP program overall. In 2017, respondents had the opportunity to provide feedback about up to three projects they worked on, and 36 project-specific responses were collected from Bronx Partners for Healthy Communities. In 2018, respondents could provide feedback about all of their projects, and 143 project-specific responses were collected.

In both years, participants were asked how effective they perceived the project to be at meeting its intended goals. An overwhelming majority of responses (90% in 2017; 92% in 2018) rated projects to be at least moderately effective (Exhibit 7). These percentages were higher than those statewide.

Exhibit 7. Bronx Partners for Healthy Communities project effectiveness ratings

	2017		2018	
	BPHC (N=32)	NYS (N=1,456)	BPHC (N=100)	NYS (N=3,177)
Extremely effective	22%	12%	15%	16%
Very effective	34%	28%	43%	28%
Moderately effective	34%	33%	34%	36%
Slightly effective	9%	19%	6%	15%
Not at all effective	0%	7%	2%	6%

Source: Authors' analysis of the 2017 and 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Note: Percentages do not total 100% due to rounding.

Partners were also asked to rate the degree to which they perceived each of their projects were changing patient care. (Again, survey respondents were able to answer separately for each project in which they participated.) Most responses indicated that projects were leading to some positive change or very positive change; 85% in 2017 and 90% in 2018. (See Exhibit 8.) These percentages were higher than those statewide.

Exhibit 8. Please indicate the degree to which you perceive the project is changing patient care

	2017		2018	
	BPHC (N=33)	NYS (N=1,573)	BPHC (N=100)	NYS (N=3,189)
Very positive change	30%	19%	32%	24%
Some positive change	55%	55%	58%	55%
No change	12%	26%	8%	19%
Some negative change	3%	<1%	2%	1%
Very negative change	0%	0%	0%	<1%

Source: Authors' analysis of the 2017 and 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Note: Percentages do not total 100% due to rounding.

Partners' satisfaction ratings of their projects are shown in Exhibit 9. In 2017, survey participants were asked about their satisfaction with project implementation, operations during Demonstration Years 0-2, and current operations

(Demonstration Year 3 at the time of the survey) of each project. In 2018, participants were asked about their satisfaction with operations of the project over the past 12 months (Demonstration Year 4 at the time of the survey). At least two-thirds of responses from Bronx Partners for Healthy Communities partner survey participants indicated that they were somewhat or very satisfied with project implementation and operation, with 88% satisfied in Demonstration Year 4. Most of these percentages were somewhat higher than those statewide.

Exhibit 9. Bronx Partners for Healthy Communities project satisfaction ratings

	Satisfaction with project implementation		Satisfaction with project operations Demonstration Year 0-2		Satisfaction with project operations Demonstration Year 3		Satisfaction with project operations Demonstration Year 4	
	BPHC (N=35)	NYS (N=1,628)	BPHC (N=34)	NYS (N=1,537)	BPHC (N=35)	NYS (N=1,622)	BPHC (N=97)	NYS (N=3,147)
Very satisfied	43%	28%	38%	27%	37%	26%	50%	33%
Somewhat satisfied	26%	39%	35%	43%	29%	40%	38%	38%
Neither satisfied nor dissatisfied	29%	23%	24%	25%	29%	24%	7%	19%
Somewhat dissatisfied	3%	6%	0%	0%	6%	6%	4%	6%
Very dissatisfied	0%	3%	3%	5%	0%	2%	1%	5%
Not applicable	0%	1%	0%	0%	0%	2%	0%	0%

Source: Authors' analysis of 2017 and 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Note: Percentages do not total 100% due to rounding.

4.d. Bronx Partners for Healthy Communities partner perceptions of value based payment readiness

As shown in Exhibit 10, just under three-fourths of respondents characterized themselves as "somewhat knowledgeable" or "very knowledgeable" of value based payment in 2017. This increased to 90% in 2018.

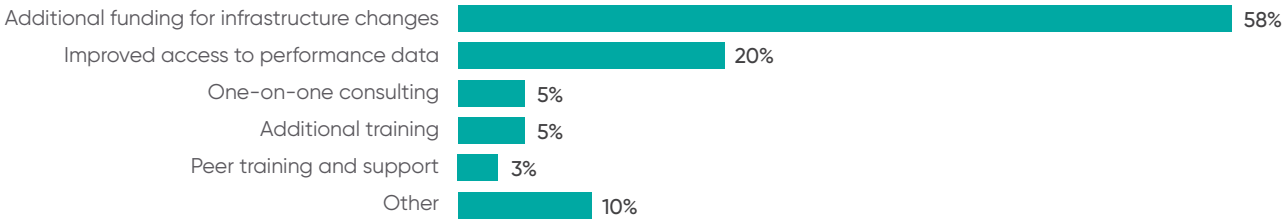
Exhibit 10. How do you characterize your understanding of value based payment?

	2017		2018	
	BPHC (N=21)	NYS (N=768)	BPHC (N=49)	NYS (N=941)
Very knowledgeable	43%	23%	37%	28%
Somewhat knowledgeable	29%	59%	53%	51%
A little knowledgeable	29%	15%	10%	19%
Not at all knowledgeable	0%	3%	0%	2%

Source: Authors' analysis of 2017 and 2018 statewide partner survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), New York State (NYS)
Note: Percentages do not total 100% due to rounding.

In 2017, just over three-quarters of respondents reported that their organizations had made changes to prepare for value based payment, while in 2018, that increased to 84%. However, most respondents still said they required more resources to facilitate the shift to value based payment (90% in 2017; 88% in 2018). In 2018, those who reported this were asked which resource would be most helpful. A total of 58% said they most needed additional funding for infrastructure changes. Another 20% requested improved access to performance data (Exhibit 11).

Exhibit 11. Which of these resources would be MOST helpful to your organization's shift to value based payment? (N=40)



Source: Authors' analysis of the 2018 statewide partner survey.

4.e. Bronx Partners for Healthy Communities patient perceptions of care

The CAHPS surveys completed by 351 Bronx Partners for Healthy Communities patients in Demonstration Year 1, 283 patients in Demonstration Year 2, and 346 patients in Demonstration Year 3 showed that overall, patients were satisfied with their primary care providers. At least three-quarters 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 over 80% experienced helpful, courteous, and respectful office staff. Exhibit 12 displays these figures, as well as those for all PPS.

Exhibit 12. CAHPS survey: BPHC Patient satisfaction with providers, DY1, DY2, and DY3

Demonstration year	Rated provider 8 or above	Getting Timely Appointment, Care, and Information	How Well Doctors Communicate with Patients	Care Coordination	Helpful, Courteous, and Respectful Office Staff
DY1 BPHC	84%	77%	92%	81%	83%
DY1 All PPS	84%	85%	92%	84%	90%
DY2 BPHC	78%	78%	92%	79%	88%
DY2 All PPS	82%	83%	91%	83%	89%
DY3 BPHC	83%	84%	92%	80%	89%
DY3 All PPS	84%	86%	93%	84%	90%

Source: Authors' analysis of the Clinician & Group CAHPS 3.0 survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), Demonstration Year (DY)

An established relationship with a primary care provider (PCP) 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. Exhibit 13 presents these findings for Bronx Partners for Healthy Communities, as well as those for all PPS. Over three-quarters of respondents (81% in DY1; 88% in DY2; 87% in DY3) indicated that 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. Over two-thirds (68% in DY1; 75% in DY2; 75% in DY3) were seeing this provider for at least one year. Over one-fourth were seeing the provider for five years or more (27% in DY1; 35% in DY2; 38% in DY3. Data not shown in Exhibit 13). Between DY1, DY2, and DY3, 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.

Exhibit 13. CAHPS Survey: BPHC Patient relationship with provider, DY1, DY2, and DY3

Demonstration year	The patient saw usual provider	Patient had been seeing provider for at least one year
DY1 BPHC	81%	68%
DY1 All PPS	79%	74%
DY2 BPHC	88%	75%
DY2 All PPS	81%	76%
DY3 BPHC	87%	75%
DY3 All PPS	87%	78%

Source: Authors' analysis of the Clinician & Group CAHPS 3.0 survey.
Abbreviations: Bronx Partners for Healthy Communities (BPHC), Demonstration Year (DY)

4.f. Bronx Partners for Healthy Communities partner DSRIP program improvement recommendations

Partner survey participants were asked to share suggestions for improvements to the DSRIP program. Several Bronx Partners for Healthy Communities respondents stated that the DSRIP program should further integrate community-based organizations in service provision and provide more financial support to them.

> *DSRIP is very hospital focused. If we are serious about decreasing hospitalizations and ER visits, then the leadership and administration of DSRIP funded programs must be done by community providers.*
> ***– 2018 Partner survey respondent***

> *More focus on behavioral health, CBOs and direct service. For the most part, DSRIP has been almost exclusively hospital and primary care focused and huge sums of money have gone to consultants, administrators and IT, while very little has trickled down to direct service staff and initiatives.*
> ***– 2018 Partner survey respondent***

A number of respondents also noted that the DSRIP program should increase emphasis on partner-to-partner collaboration, including greater awareness of other health care agencies.

> *Stronger encouragement to have DSRIP partners share and "partner" with each other.*
> ***– 2018 Partner survey respondent***

> *All health care systems need to be aware of the purpose, process and culture of other care delivery entities.*
> ***– 2018 Partner survey respondent***

A few respondents expressed that continued emphasis on sustainability and continued funding of projects and programs was critical.

> *DSRIP has placed organizations on the path to be self-sustaining but we are not quite there yet.*
> ***– 2018 Partner survey respondent***

4.g. Bronx Partners for Healthy Communities focus group aggregated responses

Bronx Partners for Healthy Communities PPS partners that participated in the research cycle 2 focus groups may have overlapped with other PPS in the New York City or Long Island area. Themes based on focus group participant responses and the other data sources, along with specific focus group participant quotes can be found in Section 4 of the soon to be

released 2019 Statewide Annual Report. Focus group quotes are aggregated at the provider level.[5] Focus group feedback was provided in the areas of project selection and approach, partner and patient engagement, educational resources and training, funds flow, PPS overlap, VBP readiness, data access, workforce, care transitions, integration of services, innovation and other positive and negative perceptions.

5. POSITIVE OBSERVATIONS AND SUGGESTED RECOMMENDATIONS FROM PARTNERS AND FROM RESEARCH FINDINGS FOR BRONX PARTNERS FOR HEALTHY COMMUNITIES PPS

5.a. Bronx Partners for Healthy Communities PPS Positive Observations

Bronx Partners for Healthy Communities PPS activities and stakeholder feedback indicate the PPS is making progress towards reaching its goals. Overall, Bronx Partners for Healthy Communities partners observed a number of positive changes due to the DSRIP program and perceptions tended to be more positive in 2018 compared to 2017, although direct comparisons between the two research cycles were not always possible. Highlights of these positive changes based on the findings presented in Section 4 are summarized below.

- **Impact of the DSRIP program on population health and patient care:** In 2018, 79% of Bronx Partners for Healthy Communities partners reported that the DSRIP program has positively impacted population health in their service area and 86% reported a positive impact on patient care, an increase from 72% and 81%, respectively, in 2017.
- **Clinical care and service benefits of the DSRIP program:** In 2018, 80% of partners surveyed from Bronx Partners for Healthy Communities reported that services or clinical care at their organization had changed for the better since the DSRIP program was initiated.[6] They also reported observing several specific benefits to patient care due to the DSRIP program. More than 60% of partners from Bronx Partners for Healthy Communities perceived more coordinated care, about half saw improved understanding of patient care and reduced avoidable hospital utilization, and over one-third saw improved clinical outcomes. Overall, 2018 survey responses on DSRIP benefits were similar to a similar item in the 2017 survey. However, in 2018 there were noticeable increases in the percent observing reduced avoidable hospital utilization (47% in 2018 vs. 33% in 2017) and improved clinical outcomes (37% in 2018 vs. 29% in 2017).

  Partner comments from Bronx Partners for Healthy Communities supported these findings of positive changes to clinical care in their service areas and emphasized improvements in care transitions, recognition of the need to address social determinants of health, better integration of behavioral and physical health, and improved electronic communication between providers. (See partner comments following Exhibit 6.)
- **DSRIP projects:**
  - **Effectiveness:** In both survey years, an overwhelming majority of respondents from Bronx Partners for Healthy Communities reported that projects were at least moderately effective (90% in 2017; 92% in 2018). In 2018, 90% of partners also reported that projects were leading to positive changes in patient care, an increase from 85% in 2017.
  - **Satisfaction:** Partner satisfaction with project operations has increased over time for Bronx Partners for Healthy Communities. A total of 88% of Bronx Partners for Healthy Communities survey respondents were satisfied with project operations in Demonstration Year 4 (the time of the 2018 survey), compared to about two-thirds of respondents who indicated satisfaction with project implementation and operations up to Demonstration Year 3 (based on the 2017 survey).
- **Value Based Payment:** Value based payment education and training efforts appear to be increasing partner understanding of value based payment. In 2018, 90% of Bronx Partners for Healthy Communities survey respondents

[5] As noted in Section 2.c., focus groups were split into four provider categories. Partners from Bronx Partners for Healthy Communities participated in each of the four provider category focus groups.

[6] Direct Comparison to the 2017 Statewide Partner Survey is not possible for this item due to wording changes to improve clarity.

described themselves as at least somewhat knowledgeable about value based payment, an increase from 72% in 2017. Organizations also appear to be increasing their efforts to prepare for value based payment. In 2018, 84% of Bronx Partners for Healthy Communities survey participants reported that their organizations had made changes to prepare for value based payment compared to 79% in 2017. Although gains are being made in preparing for the shift to value based payment, some additional resources may still be needed as noted in Section 5.b.

5.b. Suggested Recommendations from Partners and from Research Findings for Bronx Partners for Healthy Communities PPS

- **Continue commitment to community-based organization inclusion:** Partners from the Bronx Partners for Healthy Communities PPS emphasized that community-based organizations are an important part of system transformation, including efforts to reduce avoidable hospital and emergency department utilization. Partners reported that although collaboration between the medical community and community-based organizations have improved, collaboration has not reached its full potential. Some partners would like to see increased partner-to-partner collaboration and greater awareness of other agencies. Some partners also perceived that DSRIP funds were going largely to infrastructure rather than direct service staff and initiatives. Bronx Partners for Healthy Communities may want to continue efforts to engage and integrate community-based organizations in initiatives and to continue to communicate its funds flow approaches with partners.
- **Continue support for the shift to value based payment:** Although 84% of partners in 2018 reported their organizations had made changes to prepare for value based payment, the majority of partners (88%) still report needing additional resources to facilitate the shift to value based payment. The resource most commonly cited by partners include additional funding for infrastructure changes. The Bronx Partners for Healthy Communities PPS may want to work with partners and stakeholders to identify specific infrastructure and performance data needs, and potential sources of funding and/or data to address those needs.

6. CONCLUSION AND PLANS FOR FUTURE RESEARCH

The Bronx Partners for Healthy Communities PPS activities and stakeholder feedback from Demonstration Years 0 through the middle of Demonstration Year 4 indicate that the PPS is making progress towards meeting its goals and transforming health care. One subsequent Bronx Partners for Healthy Communities PPS-specific report will be provided in 2020 (covering the second half of Demonstration Year 4 and a portion of Demonstration Year 5).

The Bronx Partners for Healthy Communities PPS and its stakeholders should also reference the soon to be released 2019 Statewide Annual Report by the Independent Evaluator for the New York State DSRIP program. This report includes summaries of major DSRIP program evaluation findings statewide to highlight areas of success and areas in need of improvement and provides preliminary findings on some DSRIP program performance metrics. A similar statewide DSRIP Interim Evaluation Report has been submitted to the Centers for Medicare and Medicaid Services (CMS) as required by the Special Terms and Conditions in summer of 2019 and is under CMS review. A final statewide Summative Evaluation Report will be published in 2021.

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 research cycle 3 which is the next, and final, year will include:

- **Key Informant Interviews:** In the summer of 2019, the Independent Evaluator will again conduct telephone interviews with PPS senior leadership. These will function as updates to their interviews regarding Demonstration Year 0 through Demonstration Year 3 that were conducted in research cycle 1. Questions will focus on shifts to payment for performance, as well as other DSRIP-related changes within Demonstration Year 5.
- **Partner Focus Groups:** The Independent Evaluator will organize the remaining focus groups with project partners in Western New York, Central New York, and the Southern Tier.

- **Partner Survey:** The electronic survey of approximately 2,400 engaged partners will be administered again in the final research cycle. The PPS will be contacted to assist in updating lists of DSRIP-engaged partners for the survey.
- **Patient Data:** Secondary analysis of the CG-CAHPS survey will be conducted for the final research cycle.

Time series analysis

The time series analysis team acquired access to the DSRIP Dataset in 2018 and have begun examining how DSRIP performance metrics have changed in the early years of the program for the NYS Medicaid population attributed to DSRIP. In the next year, the team will examine additional performance measures and additional years of data, as they become available.

Comparative analysis

The comparative analysis team acquired access to the DSRIP Dataset in 2018 and have begun assessing relative PPS performance over time and will continue this work over the next year. This work will be supplemented by qualitative data emanating from the implementation and process study to further contextualize the findings.

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Appendices

APPENDIX 1: KEY INFORMANT INTERVIEW GUIDES

Appendix 1 includes the guides used for the key informant interviews in each research cycle completed to date. Key informant interviews were conducted by telephone and lasted between 60 and 90 minutes.

Project Leader Key Informant Guide 2018

1. What are some of the biggest challenges your PPS experienced (during years 0-present) of project implementation?
2. What are some of the biggest successes that you experienced during project implementation?
3. What data are being collected by your PPS and/or NYS DOH that you believe to be the most important to understanding overall DSRIP project success?
4. From your perspective, how valuable is the support provided by NYS DOH and its consultants (i.e. KPMG, PCG- IA, ASTs)?
5. What have you done to prepare for the shift to value-based payment?
6. In your view, have DSRIP projects changed the health care system?
7. Is there anything you would like to comment on regarding DSRIP in general?

PPS Executive Team Key Informant Interview Guide 2017

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 (e.g., years 0-2) of project implementation?
3. What are some of the biggest successes that you have experienced during the early phases (e.g., years 0-2) of project implementation?
4. Please tell us about PPS committees that are related to its governance and about the effectiveness of your PPS' committees in meetings 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?

APPENDIX 2: STATEWIDE PARTNER SURVEY METHODOLOGY

The section below expands on the methodology for the statewide Partner Survey presented in Section 2.b. Numbers provided are New York statewide. The number of surveys received and the response rate for this PPS are described in Section 2.b.

Sampling, Recruitment, and Data Collection Procedures

Annual electronic partner surveys collected information about perceptions of the DSRIP program and the function of individual projects. The key informant interviews and focus groups had flexible interview guides designed to allow participants to elaborate on topics for a deeper understanding, and used purposive sampling. In contrast, the surveys were designed to collect information about representative viewpoints through a uniform survey (i.e., all participants received an identical survey) and invitations for all PPS engaged partners to participate.

To identify respondents in the first survey cycle, the Independent Evaluator built a unique contact list of partners for each of the 25 PPS by merging the Medicaid Analytics Performance Portal (MAPP) network tool with the Provider Export/Import Tool (PIT)/ Provider Export/Import Tool-Revised (PIT-R). The list reflected PPS networks in DY2. Each PPS primary contact was sent the list of partners generated for their PPS and asked to: (1) identify which partners were engaged with projects, and (2) provide contact and engagement status information for any additional partners engaged with projects. Twenty-four of the 25 PPS responded and returned an updated list of engaged partners. For the remaining PPS, survey invitations were sent to all partners in the DSRIP DY2 network list.

A similar approach was used to identify respondents in the second survey cycle. A new list of partners, based on PPS networks in DY3, was obtained from the NYS DOH's vendor that manages the Medicaid Data Warehouse. The new lists were compared to the lists used in the first survey cycle to identify any new providers. Each PPS was asked to review the updated list that included engaged partners identified the previous year as well as new providers, identify additional engaged partners that were not yet on the list, and indicate if any partners were no longer engaged. All 25 PPS responded for research cycle 2 and returned an updated list of engaged partners.

A survey invitation was sent to each email address corresponding to an engaged provider, with a personalized link to the survey in Qualtrics. In total, survey links were sent to 2,794 email addresses in the first cycle, and 2,171 valid email addresses in the second cycle. Fewer invitations were sent in the second cycle because PPS were better able to specifically identify engaged partners and all PPS returned an updated list of engaged partners. As some partners were part of several PPS, in the first data collection cycle they received multiple requests for the survey. These multi-PPS partners were asked to respond to one survey only. Simultaneously, contacts at each PPS were encouraged to alert their provider network to the survey and encourage completion. This partner survey reminder was shared via PPS newsletters, Project Advisory Committee meetings and other PPS events. As an incentive to complete the Independent Evaluation survey, participants in the first cycle were informed that three respondents would win a $100 Amazon gift card.

Providers could be individual practitioners or organizations. In some cases, only one email address was available for multiple providers (e.g., a medical practice may have provided one contact email for multiple staff doctors, or a community-based organization with multiple involved staff members may have used one business email). Because of this, participants were allowed to forward the invitation to other members of their organization. As such, there is no direct correspondence between email address and individual respondents.

For the first cycle, the survey launched in September 2017 on the Qualtrics online survey platform and closed in November 2017. Potential participants who had not completed the survey were sent eight 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. 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 provide a coherent response in any text box, including their name). These methods resulted in 897 usable responses, for a final response rate of 32.1%. Individual respondents could answer project evaluation questions for up to three projects, resulting in a total of 1,689 project-based evaluations.

For the second cycle, the survey launched in September 2018 and closed in October 2018, with eight reminder emails. A total of 1,071 completed surveys from unique individuals were returned, for a final response rate of 49.3%. For this cycle, individual respondents could answer project evaluation questions for all the projects they were actively involved with, rather than just three projects as in the first cycle. This resulted in a total of 3,621 project-based evaluations.

Survey Design

The partner survey (see Appendix 3) was developed to gather information on progress within individual projects, barriers and facilitators to project implementation, perceived effectiveness of the projects, and the DSRIP program overall. The NYS DOH provided feedback on and final approval for the Independent Evaluator's designed survey. Most questions were Likert scales, with supplemental open-ended questions where participants could elaborate on their responses.

Survey topics included:

- Service provision and project operations
- Factors that helped or hindered their implementation
- Level of satisfaction with project operations
- Reflections on what worked well and less well
- Overall perception of the DSRIP program
- Overall perception of DSRIP projects
- Preparations for value based payment

Each respondent was allowed to select projects to evaluate individually. Thereafter, they received a battery of questions corresponding to each project they selected. This yielded more project-based responses than number of participants.

Most survey items were kept consistent across cycles to allow for interpretation of changes over time. Some questions were modified in the second cycle, based on feedback from the first cycle and emerging topics. Changes included adjusted time frames, dropping questions about early implementation, and adding items about the specific resources needed to transition to value based payment (see Appendix 3).

Data Analysis

Survey responses were first de-duplicated. In each cycle, 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), but if they completed similar amounts each time, the first response was kept. If a participant in the first cycle 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 program projects in one survey entry, then retook the survey and answered regarding 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. In the first cycle, of the 1,753 potentially usable individual project evaluations received, 265 (15.1%) were for a project that had not been implemented in the selected PPS. For example, across the sample, 70 (4.0%) 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 name was corrected. Using these procedures, 201 responses were corrected. A total of 64 responses were unable to be recoded and so these were not included in any further analyses, leaving 1,689 project-based responses, inclusive of all 25 PPS.

The final set of 1,689 project-based evaluations in cycle 1 covered all DSRIP projects and included all 25 PPS across New York. There was a wide range in the number of responses a PPS received. On average, PPS received about 68 responses each (standard deviation of 37). There were no project responses for Projects 3.b.ii, 3.d.i, 3.h.i, 4.c.iii, and 4.c.iv, as they were not implemented by any PPS. A total of 3,621 project-based evaluations were received in cycle 2; on average PPS received about 145 responses each (standard deviation of 79). A total of 34 of these responses were for a project that the selected PPS was not implementing. These responses were recoded as described above.

Survey responses were summarized descriptively as means and the percentage of respondents selecting each item in the five-point scales. The "do not know" responses were not combined with the neutral response (e.g., "did not improve or worsen") because conceptually, they are distinct.

APPENDIX 3: STATEWIDE PARTNER SURVEY INSTRUMENTS

Statewide Partner Survey Instrument 2018

The Independent Evaluator of the New York State Delivery System Reform Incentive Payment (DSRIP) program is conducting a survey of project partners. The survey includes questions about your perceptions of DSRIP and how DSRIP has affected organizations and patients.

Your feedback will help improve programs by letting the Department of Health and your PPS know which aspects of DSRIP have been effective and which have not. Evaluating these changes each year helps determine whether improvements are taking place over time.

1. What type of organization do you work for?[7]

Community-based organization
Primary care provider
Non-primary care practitioner
Clinic
Hospital
Behavioral health organization
Substance use treatment organization
Skilled nursing facility/ nursing home
Hospice/ palliative care center
Home care agency
Government office
Pharmacy
Health home/ care management program
Other (specify)

The next items ask about your perceptions of DSRIP overall. The survey will ask about your specific projects in a later section.

2. How have the services or clinical care at your organization changed since DSRIP was initiated?

Very positive change
Some positive change
No change
Some negative change
Very negative change

3. Have you observed any of the following benefits from DSRIP? (Please select all that apply).

More coordinated care
Improved recognition of mental health disorders
Increased primary care provider use of behavioral health intervention
Improved understanding of patient needs
Improved patient satisfaction
Improved clinical outcomes
Reduced avoidable hospital utilization
Reduced medical costs
None of the above

[7] This is a partner self-selected category type.

4. [Skip if 3= none of the above] Do you expect these benefits to continue after DSRIP funding ends?

[List each benefit respondent selected above with yes/no/ I don't know options for each]

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

Yes, very positive change
Yes, some positive change
No change
No, some negative change
No, very negative change
I don't know

6. Do you believe DSRIP has changed any aspect of population health within your service area?

Very positive change
Some positive change
No change
Some negative change
Very negative change
I don't know

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

Extremely effective
Very effective
Moderately effective
Slightly effective
Not at all effective

8. In what ways do you feel that DSRIP is working well?

9. Please share any suggestions you have for program improvements for DSRIP.

The next set of questions will ask about value based payment.

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

Very knowledgeable
Somewhat knowledgeable
A little knowledgeable
Not at all knowledgeable

11. Has your practice or organization made changes to prepare for value based payment?

Yes
No

12. Do you require more resources to facilitate the shift to value based payment?

Yes
No

13. [If 12=yes] What types of resources would help your organization shift to value based payment?

Additional training (specify training topics: _____)
One-on-one consulting
Additional funding for infrastructure changes
Peer training and support
Improved access to performance data (specify data types: _____)
Other (specify: _____)

14. [If any responses selected in 13] Which of these resources would be MOST helpful to your organization's shift to value based payment? [List all selected in 10]

The following section will ask for your perceptions of DSRIP projects.[8]

15. Please select each PPS you work with on projects.

16. Below is a list of [PPS] projects. Please select each project with which you are actively involved. [List customized by PPS] [Repeat per PPS]

17. Please indicate your level of satisfaction with the past 12 months of operation of <Project> at <PPS>.
- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Very dissatisfied
- Not applicable

18. Please indicate the degree to which you perceive the project is changing patient care.
- Very positive change
- Some positive change
- No change
- Some negative change
- Very negative change

19. How effective do you currently perceive the project to be at meeting its intended goals?
- Extremely effective
- Very effective
- Moderately effective
- Slightly effective
- Not at all effective

[#17,18, 19 repeated for each PPS's projects]

20. [After all projects] Is there anything else you would like to share about DSRIP?

[8] Partner responses were limited to up to 3 projects in the 2017 survey. There were no such limitations in the 2018 survey; partners could provide responses about all projects with which they participated.

Statewide Partner Survey Instrument 2017

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.

2019

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Independent Evaluation

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Bronx Partners for Healthy Communities PPS

DSRIP Demonstration Year 0 – DSRIP Year 4

NEW YORK STATE | Department of Health

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