STATE OF NEW JERSEY DEPARTMENT OF HEALTH

Delivery System Reform Incentive Payment (DSRIP) Program Planning Protocol

Section 93(e) of the Special Terms and Conditions (STCs) for New Jersey's "Comprehensive Waiver" section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services requires the development of "a DSRIP Planning Protocol" to be submitted to CMS for approval. The Department of Health designed and shall administer the DSRIP program. This document represents the Department's final draft to the Centers for Medicaid & Medicaid Services (CMS).

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TABLE OF CONTENTS

I. Preface 3
A. Delivery System Reform Incentive Payment Program 3
B. DSRIP Planning Protocol and Program Funding and Mechanics Protocol 3
C. High Level Organization of "Attachment H: Planning Protocol" 4
II. DSRIP Eligibility Criteria 4
III. Global Context, Goals, and Outcomes 6
IV. Project Stages 11
V. DSRIP Project Array 12
A. Asthma 14
B. Behavioral Health 17
C. Cardiac Care 21
D. Chemical Addiction/Substance Abuse 24
E. Diabetes 26
F. HIV/AIDS 29
G. Obesity 32
H. Pneumonia 34
VI. Stage 3 Measures (Project-Specific Metrics) 36
VII. Stage 4 Measures (Universal Metrics) 37
A. Attribution 38
VIII. Requirements of the Hospital DSRIP Plans 38
A. DSRIP Plans 38
B. Project Activities, Milestones, and Metrics 44
IX. Quality & Measures Committee (Committee) 45
A. Composition of the Committee 46
X. DSRIP Program Performance Management 46
A. New Jersey DSRIP Performance Management 47
B. Learning Collaborative 48
C. DSRIP Program Evaluation 50

DRAFT - SUBJECT TO CHANGE

I. Preface

A. Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS) in October 2012. DSRIP seeks to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement by transitioning funding from the current Hospital Relief Subsidy Fund (HRSF) to a model where payment is contingent on achieving health improvement goals by hospitals. Hospitals designated as DSRIP participating hospitals will receive 2013 HRSF Transition Payments in demonstration year (DY) 1 and in July through October 2013 of DY2. The DSRIP Funding Pool is available after the Transition Payment period through the end of DY5 for the development of a project which includes activities that support the hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve.

The project activities funded by the DSRIP Program will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with this DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a project that is designed to improve the quality of care provided, the efficiency with which care is provided, and the overall population health.

Hospitals may qualify to receive incentive payments (DSRIP payments) for fully meeting performance and outcome metrics (as specified in this Planning Protocol, as well as the Funding and Mechanics Protocol), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

B. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Planning Protocol submitted for approval by the New Jersey Department of Human Services to the Centers for Medicare &

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Medicaid Services. This document is Version 0.8, dated July 10, 2013. Please also refer to the accompanying Attachment 1: DSRIP Toolkit containing the framework for each project, the clinical and quality protocols developed for this initiative, as well as the reporting requirements for the DSRIP Program.

C. High Level Organization of "Attachment H: Planning Protocol"

Attachment H has been organized into the following sections.

I. Preface
II. DSRIP Eligibility Criteria
III. Global Context, Goals, and Outcomes
IV. Project Stages
V. DSRIP Project Array
VI. Stage 3 Measures (Project-Specific Metrics)
VII. Stage 4 Measures (Universal Metrics)
VIII. Requirements of the Hospital DSRIP Plans
IX. Quality & Measures Committee
X. DSRIP Program Performance Management

II. DSRIP Eligibility Criteria

The hospitals eligible to receive funding under the DSRIP program are those general acute care hospitals and are listed and shown in the table below.

Table I. HOSPITALS ELIGIBLE FOR TRANSITION AND DSRIP PAYMENTS

Medicaid No.	Medicare No.	Hospital Name	County
4139402	310064	ATLANTICARE REG'L MEDICAL CENTER	ATLANTIC
4136705/0167011	310025	BAYONNE HOSPITAL	HUDSON
4141105	310112	BAYSHORE COMMUNITY HOSPITAL	MONMOUTH
4139003	310058	BERGEN REG'L MEDICAL CENTER	BERGEN
4135709	310011	CAPE REGIONAL MEDICAL CENTER	CAPE MAY
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS	MERCER
4138201	310044	CAPITAL HEALTH SYSTEM - HOPEWELL	MERCER
4141008	310111	CENTRASTATE MEDICAL CENTER	MONMOUTH
4136209	310017	CHILTON MEMORIAL HOSPITAL	MORRIS
3674207	310016	CHRIST HOSPITAL	HUDSON
4135504	310009	CLARA MAASS MEDICAL CENTER	ESSEX
3674606	310041	COMMUNITY MEDICAL CENTER	OCEAN
4136004	310014	COOPER UNIVERSITY MEDICAL CTR	CAMDEN
4137205	310031	DEBORAH HEART & LUNG CENTER	BURLINGTON
4140001	310083	EAST ORANGE GENERAL HOSPITAL	ESSEX
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION	BERGEN

DRAFT - SUBJECT TO CHANGE

Medicaid No.	Medicare No.	Hospital Name	County
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER	BERGEN
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL	WARREN
4137906/0249297	310040	HOBOKEN HOSPITAL CENTER	HUDSON
4135407	310008	HOLY NAME HOSPITAL	BERGEN
4135202	310005	HUNTERDON MEDICAL CENTER	HUNTERDON
4139801	310074	JERSEY CITY MEDICAL CENTER	HUDSON
3675700	310073	JERSEY SHORE MEDICAL CENTER	MONMOUTH
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	MIDDLESEX
4140206	310086	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	CAMDEN
3676200	310084	KIMBALL MEDICAL CENTER	OCEAN
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY	BURLINGTON
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER	HUDSON
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY	OCEAN
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	BURLINGTON
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY	SALEM
3675807	310075	MONMOUTH MEDICAL CENTER	MONMOUTH
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL	MORRIS
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL	ESSEX
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER	ESSEX
4137001	310028	NEWTON MEMORIAL HOSPITAL	SUSSEX
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER	CAMDEN
3674801	310051	OVERLOOK HOSPITAL	UNION
4135105	310003	PALISADES GENERAL HOSPITAL	HUDSON
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL	MIDDLESEX
4137809	310039	RARITAN BAY MEDICAL CENTER	MIDDLESEX
4137400	310034	RIVERVIEW MEDICAL CENTER	MONMOUTH
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL	UNION
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	MERCER
3674703	310047	SHORE MEMORIAL HOSPITAL	ATLANTIC
4138406	310048	SOMERSET MEDICAL CENTER	SOMERSET
3674509	310032	SOUTH JERSEY HEALTH SYSTEM	CUMBERLAND
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER	SALEM
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL	OCEAN
3675904	310076	ST. BARNABAS MEDICAL CENTER	ESSEX
4138601	310050	ST. CLARE'S-RIVERSIDE MED CTR DENVILLE	MORRIS
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)	MERCER
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	PASSAIC
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)	PASSAIC
4140508	310096	ST. MICHAEL'S MEDICAL CENTER	ESSEX
4139500	310070	ST. PETER'S MEDICAL CENTER	MIDDLESEX

DRAFT - SUBJECT TO CHANGE

Medicaid No.	Medicare No.	Hospital Name	County
4136900	310027	TRINITAS - ELIZABETH GENERAL	UNION
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL	GLOUCESTER
3677001	310119	UNIVERSITY HOSPITAL	ESSEX
4135601	310010	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	MIDDLESEX
4135806	310012	VALLEY HOSPITAL	BERGEN
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	WARREN
3674304	310022	VIRTUA - WEST JERSEY HEALTH SYSTEM	CAMDEN
Hospital Count	**63**		

Note: St. Clare's Sussex #310120 closed Inpatient operations in Oct 2012.

III. Global Context, Goals, and Outcomes

The current landscape of New Jersey health starts with the state's vision for all New Jerseyans. As specified in the Healthy New Jersey 2020 (HNJ2020) plan, that vision is for New Jersey to be a state in which all people live long, healthy lives. This vision applies to 8.7 million[1] residents of the state.

Healthy New Jersey is the state's health improvement plan and sets the agenda for comprehensive disease prevention and health promotion for New Jersey for the next decade. It is modeled after the federal Healthy People 2020 initiative and is the result of a multiyear process that reflects the input from a diverse group of individuals and organizations.

The HNJ2020 objectives communicate high-priority health issues. A principal goal stated in the HNJ2020 is to: "*Attain high-quality, longer lives free of preventable disease, disability, injury, and premature deaths*."

Specifically, New Jersey's Leading Health Indicators reflect the state's major public health concerns. New Jersey's Leading Health Indicators are the product of an extensive external and internal feedback process. Over 200 partners participated in a poll and a refined list was vetted and presented to the Department of Health's HNJ2020 Advisory Committee. The five Leading Health Indicators include 1) access to primary care, 2) birth outcomes, 3) childhood immunizations, 4) heart disease and 5) obesity.

The Department believes that the goals for three of the five leading health indicators will be influenced by the DSRIP program through implementing interventions that impact chronic care within New Jersey. As specified in the HNJ2020, the table below represents baseline and target rates for access to primary care, heart disease and obesity.

[1] The Kaiser Family Foundation, ""State Health Facts, Demographics and the Economy" *kff.org/statedata/,* accessed June 25, 2013

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Table II. HNJ2020 Baseline and Target Rates for Access to Primary Care, Heart Disease and Obesity

Leading Health Indicator	Measurement	Baseline	Target
Access to Primary Care	Increase the proportion of adults with a personal doctor or health care provider	(2011) 83.0%	(2020) 90.0%
Heart Disease	Reduce the death rate due to coronary heart disease	(2007) 140.1 per 100,000 population (age-adjusted)	(2020) 112.1 per 100,000 population (age-adjusted)
Obesity	Prevent an increase in the proportion of the population that is obese	Adults (20+; 2011) 23.8%	Adults (2020) 23.8%

Although the HNJ2020 is set to improve the lives of all residents, particular attention must be spent on the most vulnerable population groups to ensure that quality care is received by everyone in the most cost effective manner. Approximately 17 percent[2] of the population lives below the poverty line. The number of residents that remain uninsured in the state is above 1.3 million[3] and nearly the same number is currently covered by Medicaid. All residents, but particularly these vulnerable populations, rely on the safety net of New Jersey hospitals to provide quality health services. The state recognizes the integral role and efforts of the state's hospital systems with attainment of these goals.

As the burden of care for all residents continues to rise, new methods to achieve excellence in health care is an important factor in obtaining value for the health care dollar. Currently, 38 cents of every New Jersey dollar is being spent in the Medicaid program on emergency department, inpatient and outpatient services.[4] Charity Care patients alone consume more than $1.35 billion in hospital care services annually in New Jersey.[5]

The DSRIP program provides an opportunity to improve patient care for New Jersey's low income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and the families they serve. These investments contribute directly to CMS's over-arching "Triple Aim" and position safety net providers for the emerging healthcare market where data, quality, and pay for performance initiatives foster competition among facilities and bend the health care cost curve.

In addition to the HNJ2020 data, the Department has observed that cardiac care, pneumonia, mood disorders, diabetes and asthma all routinely rank in the top 20

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[2] The Kaiser Family Foundation, "State Health Facts: Health Coverage," kff.org/statedata/, accessed June 25, 2013
[3] The Kaiser Family Foundation, "State Health Facts: Health Coverage," kff.org/statedata/, accessed June 25, 2013
[4] Data based on SFY 2011 CRCS NJ Medicaid Managed Care Capitation Rates
[5] New Jersey Hospital Association (2010). "Charity Care Patient Profile: A Deeper Exploration"

for total number of inpatient discharges by principal diagnosis as shown on Table III.

Table III. State Statistics - 2011 New Jersey - Principal Diagnosis Only

Rank order of Clinical Classifications Software (CCS) principal diagnosis category by number of discharges			
Rank	**CCS Principal Diagnosis**	**CCS Category Name**	**Total Number of Discharges**
1	218	Liveborn	101,469
2	108	Congestive heart failure, nonhypertensive	29,519
3	2	Septicemia (except in labor)	28,166
4	122	Pneumonia (except that caused by tuberculosis and sexually transmitted diseases)	27,861
5	657	Mood disorders	25,414
6	106	Cardiac dysrhythmias	24,784
7	197	Skin and subcutaneous tissue infections	21,495
8	101	Coronary atherosclerosis	19,457
9	127	Chronic obstructive pulmonary disease and bronchiectasis	19,030
10	203	Osteoarthritis	18,626
11	102	Nonspecific chest pain	18,317
12	100	Acute myocardial infarction	18,224
13	159	Urinary tract infections	18,028
14	195	Other complications of birth, puerperium affecting management of the mother	17,258
15	109	Acute cerebrovascular disease	16,217
16	50	Diabetes mellitus with complications	16,156
17	237	Complication of device, implant or graft	15,877
18	189	Previous C-section	15,226
19	128	Asthma	15,106
20	149	Biliary tract disease	14,031
State statistics from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases 2011, Agency for Healthcare Research and Quality (AHRQ), Based on data collected by the New Jersey Department of Health and Senior Services and provided to AHRQ. These data reflect 2010 hospital characteristics.			

Therefore, in order to focus the DSRIP incentive budget and resources to meet the state's vision, New Jersey is seeking to move the cost and quality curve for eight prevalent or chronic conditions. These focus areas are as follows:

1) Asthma
2) Behavioral Health
3) Cardiac Care
4) Chemical Addiction/Substance Abuse
5) Diabetes
6) HIV/AIDS
7) Obesity
8) Pneumonia

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Chronic diseases are responsible for about 70% of all deaths nationally even while patients with chronic disease consume 83% of all health care spending in the United States.[6] This experience is observed in New Jersey where seven of the ten leading causes of death are due to chronic diseases as shown in Figure I below.

Figure I. Leading Causes of Death, New Jersey and the United States, 2009[7]

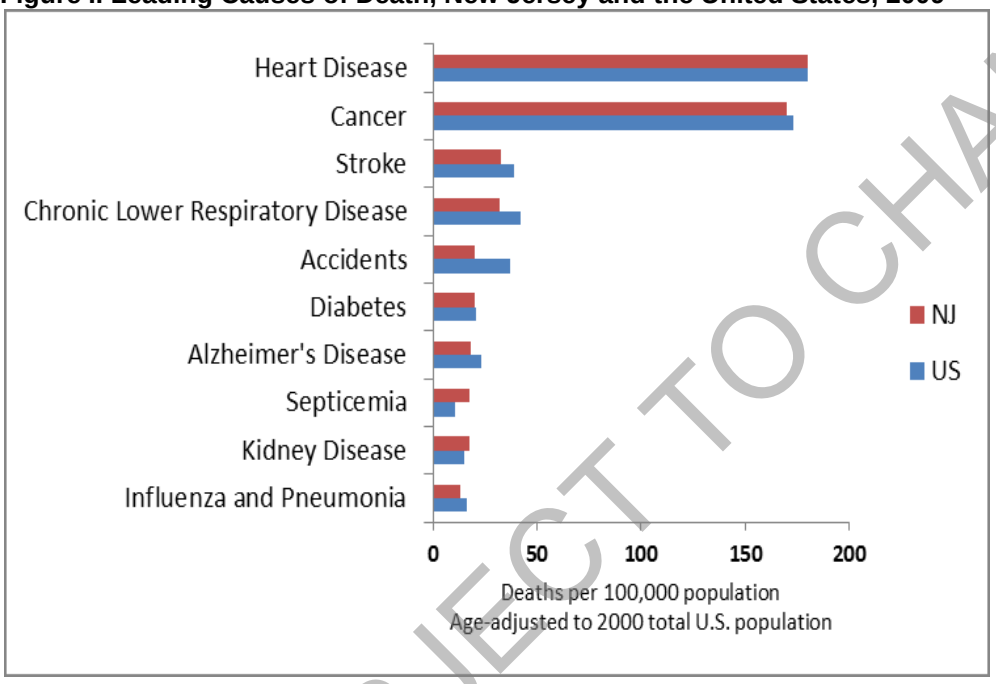

Figure II, below, demonstrates that heart disease, cancer, stroke, and diabetes caused 58% of New Jersey deaths in 2009.

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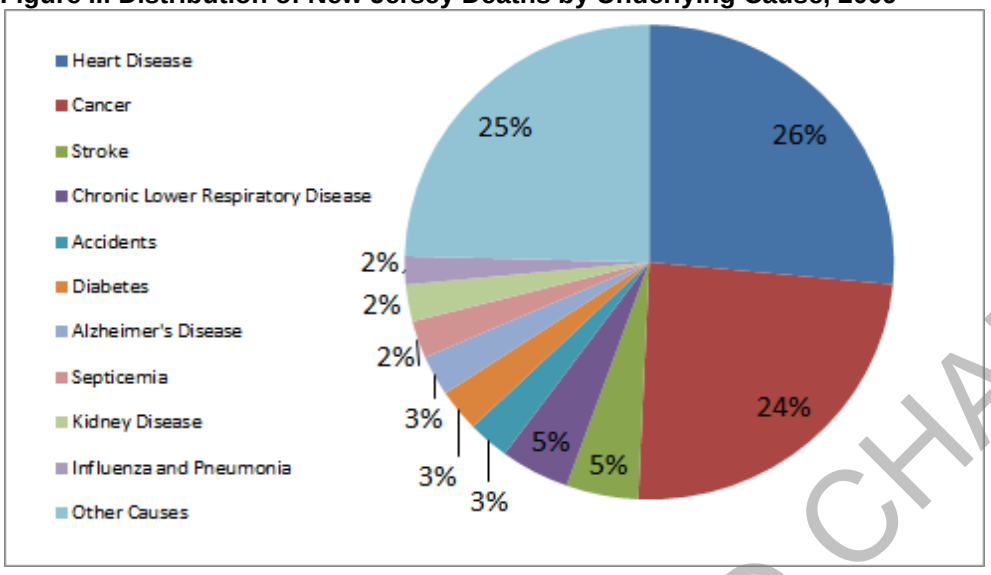
[6] New Jersey Department of Health, "Introduction to CD Burden"
[7] Ibid.

Figure II. Distribution of New Jersey Deaths by Underlying Cause, 2009[8]



Fiscally, the impact is sizeable. New Jersey spent $21,936 per disabled enrollee in 2009. Compared to the national average of $15,840,[9] this annual per enrollee cost is unsustainable. In order to bring this average down, particular attention must be spent on the at-risk disabled population that may rely on government-funded medical assistance over the course of their lifetime.

Better health management, particularly in members that have multiple chronic conditions, results in improved health outcomes, reduced cost and improved patient satisfaction in treatment. There is a great deal of emerging data to support that these chronic conditions, when effectively managed, could produce cost savings by up to five percent.[10] This is accomplished by improving population health through ensuring that the continuum of patient care is holistic in nature, improving transitions between settings of care and providing optimum care in acute circumstances which are all major features of DSRIP.

Clinical protocols or projects that will be completed by participating hospitals have been designed to achieve one or more core achievement themes, which are specific aims of the New Jersey Department of Health. These core achievement themes guided the selection of the projects within each focus area. These include:

- Improved Care/Case Management
- Improved Discharge Planning
- Expansion of Primary Care
- Improved Quality of Care

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[8] New Jersey Department of Health, "Introduction to CD Burden"

[9] "The Kaiser Family Foundation, statehealthfacts.org "Health Coverage" accessed January 31, 2013

[10] Urban Institute, www.urban.org, "The Potential Savings from Enhanced Chronic Care Management Policies," John Holahan, Cathy Schoen, and Stacey McMorrow, November 2011.

- Improved Access to Care
- Improved Patient Education
- Improved Delivery of Care
- Improved Training and Efficiency
- Any Combination of the Above

This Planning Protocol includes a menu of 17 pre-defined projects with activities that will create financial incentives for New Jersey hospitals to implement programs and interventions to improve care for residents within the eight focus areas. These projects were identified and developed by the Department and the hospital industry because they represent realistic and achievable improvement opportunities for New Jersey.

IV. Project Stages

This section describes the project stages per subparagraph (c) of the STCs, as well as the menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects.

As specified by the STCs, and as further developed in the DSRIP protocols, the project stages are as follows:

a. *Stage 1: Infrastructure Development* – Activities in this stage develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
b. *Stage 2: Chronic Medical Condition Redesign and Management* – Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
c. *Stage 3: Quality Improvements* – This stage involves the measurement of care processes and outcomes that reflect the impact of Stage 1 and Stage 2 activities, in which major improvements in care can be achieved from January 1, 2014 through DY5. Stage 3 measures the clinical performance of the hospital's DSRIP project.
d. *Stage 4: Population Focused Improvements* – Activities in this stage include reporting measures across several domains selected by the Department, in consultation with the New Jersey hospital industry and CMS.

The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for completion by month and year. While the targeted completion by month/year will

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be determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.

The Hospital DSRIP Plan Template includes all high-level Stage 1, 2, 3 and 4 activities, milestones and metrics and provides New Jersey hospitals with the universal format (framework) for the content that is needed, at a minimum, for completing their hospital-specific DSRIP plan submission. This universal application process allows for assuring all projects incorporate required activities resulting in a simplified Department and CMS review process.

Upon project selection by the hospital, it is the duty of the hospital to complete the application so that it fully describes the hospital-specific implementation. The template directs the hospital to insert pre-defined information and also requires the hospital to insert free-form text in order to describe, in more detail, the hospital's plan in accomplishing the activities, actions and milestones.

On the hospital DSRIP Plan application, the participating hospital will be required to identify key project components and goals. This initial activity acts as the foundation for completing DSRIP project planning and goal-setting. In Stage I, some activities may, or may not, apply to the chosen project based on the methodology scope. Each hospital must assess whether the listed activity is applicable to their chosen project. If the activity applies to their chosen project, the hospital will be required to provide additional narrative that fully describes how the activity will be fulfilled. If the activity does not apply, the hospital will denote N/A or Not Applicable for that activity, as well as provide a brief explanation for why the activity is not appropriate. All Stage 2, 3 and 4 activities are required.

For additional information regarding the project stages, menu of activities, projects, associated population-focused objectives and evaluation metrics, please refer to Attachment 1: DSRIP Toolkit.

V. DSRIP Project Array

As mentioned, a project array of condition-specific projects has been chosen and developed based on the eight conditions listed in the Special Terms and Conditions. These conditions represent prevalent, high cost, and/ or preventable conditions that impact the underserved populations and New Jersey's systems of healthcare.

By implementing the core achievement themes for the selected focus areas, DSRIP will provide an unprecedented opportunity to improve patient care for low-income populations in New Jersey. The New Jersey health care system will

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move from serving these patients separately at different sites of care, to one that effectively and seamlessly manages transitions of care as they occur. DSRIP projects engage inpatient and outpatient providers to share accountability in improving the overall patient health of the low-income population. Improving the care for this specific population will positively advance the overall health of the state in order to achieve the HNJ2020 goals.

Project detail for each pre-defined condition-specific project is included in Attachment 1: DSRIP Toolkit, Section III. These project detail sheets are modeled using the Hospital DSRIP Plan Template and will be used by the hospitals as a reference when completing their individual DSRIP plan. Each project detail sheet presents the project's defined objective, high level methodology, and anticipated outcomes. This information must be included within the hospital's application submission and will be pre-populated based on the pre-defined project selected. The hospital is responsible for describing in further detail the manner and means by which the hospital will fulfill the project.

If the hospital chooses to select a "off-menu" or "unique" project that is not one of the pre-defined projects under the eight Focus Areas listed in the Special Terms and Conditions or chooses to select a project that is for a condition other than the eight Focus Area conditions, the hospital will be required to develop the project's defined objective, high level methodology, anticipated outcomes, and project-specific metrics. The hospital's analysis must present strong and compelling justification for the "off-menu" project, showing that the hospital reviewed the menu projects and found that the proposed project could not be accommodated within any of the model projects of the toolkit, and that the hospital should implement the proposed off-menu project instead of a menu project.

With this justification, the hospital must show, using internal and external data, that the new hospital project is beyond those in the toolkit, that it would achieve the Triple Aim, that it is responsive to local data and community needs, and that it addresses an area of poor performance and/or health care disparity that is important to the Medicaid and/or uninsured population. The hospital must explain why this "off-menu" project is particularly innovative or promising, and that is employs an evidence-based approach (with literature clearly cited).

"Off-menu" projects must be focused on an area or condition in which there is demonstrable need for improvement, be outpatient focused, and have clearly identified improvement objectives that can be measured using nationally-endorsed (primarily outcome) metrics (such as those endorsed by the National Quality Forum (NQF) or National Committee for Quality Assurance (NCQA)). A reasonable explanation must be established that the project will result in measurable improvements in the patient population's clinical outcomes.

Hospitals choosing to submit this type of plan are advised that the plan will be subject to higher scrutiny as the project has not been pre-approved by both the

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Department and CMS.

Further rationale behind the selection of each of the eight conditions, as well as an overview of each pre-defined condition-specific project, is described below.

A. Asthma

In New Jersey, over 500,000 adults and over 180,000 children are estimated to currently have asthma.[11] Asthma is a chronic respiratory disease that is characterized by inflammation and episodic narrowing of the airways that carry oxygen in and out of the lungs. Asthma is a chronic disease that cannot be cured, but it can be controlled with an effective medical management plan, treatment of coexisting medical conditions and avoidance of environmental or occupational triggers.

As shown in the following graphs, hospitalization due to asthma was at 16,608 in 2009, though hospitalization rates for asthma do not represent the total burden of the illness. The total number of asthma emergency department (ED) visits per year ranged from 49,237 to 52,753 during 2004-2009[12].

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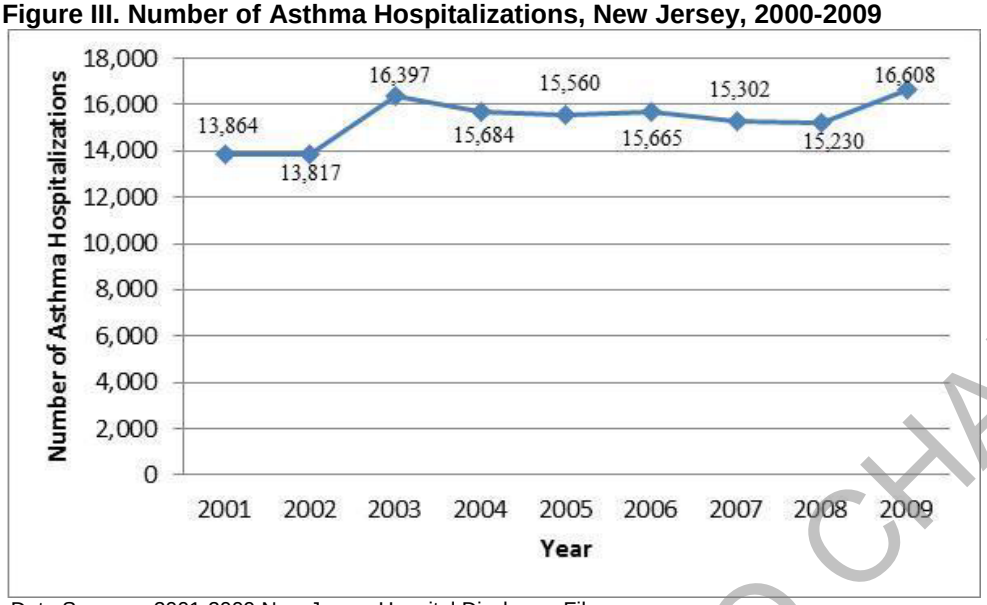
[11] NJDOH, "Addressing Asthma in New Jersey Factsheet": http://nj/gov/health/fhs/asthma/documents/aaep_summary.pdf

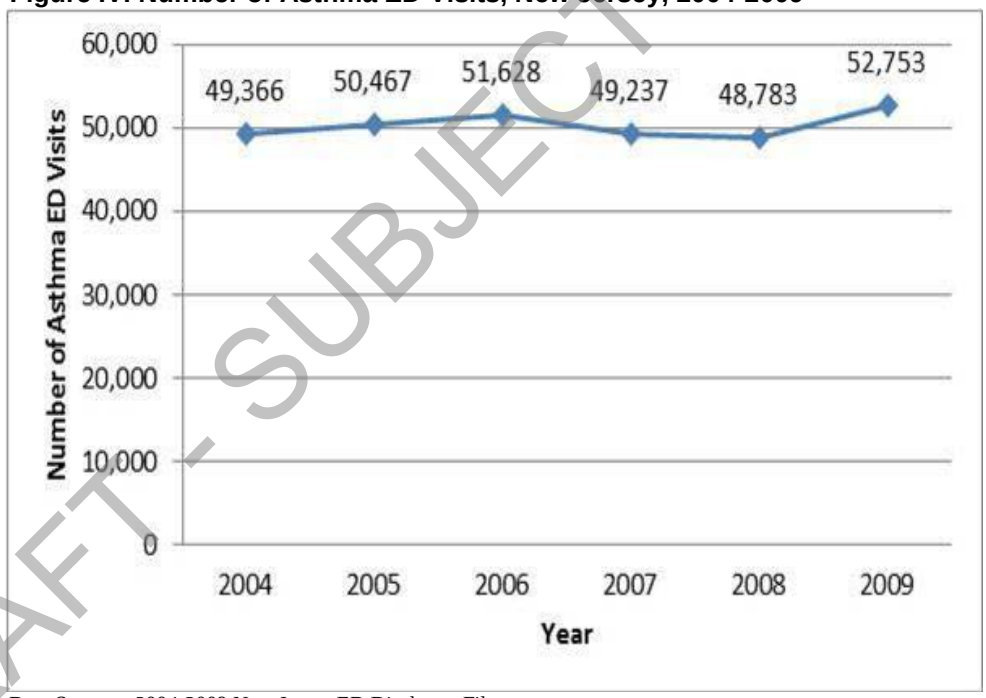
[12] NJDOH, New Jersey Asthma Awareness and Education Program: http://nj.gov/health/fhs/asthma/documents/chapter6.pdf

Figure III. Number of Asthma Hospitalizations, New Jersey, 2000-2009



Data Source – 2001-2009 New Jersey Hospital Discharge Files.

Figure IV. Number of Asthma ED Visits, New Jersey, 2004-2009



Data Source – 2004-2009 New Jersey ED Discharge File

Of particular concern, children ages 0-4 have the highest asthma hospitalization and emergency department (ED) visit rates compared to all age groups; however, about 62% of all asthma ED visits and about 74% of all asthma

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hospitalizations are for adults[13]. Additionally,

- About 9.1% of New Jersey children 0-17 years have asthma.[14]
- Approximately 7.7% of adults in New Jersey have asthma.[15]
- Annual asthma hospitalization and ED visit rates vary widely by county in New Jersey. Age-adjusted asthma ED visit rates range from 232 per 100,000 (Hunterdon) to 1,254 per 100,000 (Essex).[16]
- 57% of children with asthma who attend school or child care miss at least one day per year for their asthma.[17]
- Among children with asthma:[18]
  - 52% have received an asthma action plan from a health professional.
  - 38% were advised by a health professional to make environmental changes.
  - 40% of those who use long-term control medication report proper use.
  - 59% of those who use quick relief medication report proper use.
- Among adults with asthma:[19]
  - 31% have received an asthma action plan from a health professional.
  - 34% were advised by a health professional to make environmental changes.
  - 52% of those who use long-term control medication report proper use.
  - 61% of those who use quick relief medication report proper use.

Strong evidence indicates that more can be done to help those with asthma control their symptoms. The goals for the HNJ2020 pertaining to asthma include reducing the death rate due to asthma, reducing hospitalizations, reducing emergency department (ED) visits and reducing the proportion of persons with asthma who miss school or work days, and to increase education by health professionals regarding positive changes a patient with asthma can make in the home, school, or work settings.

In order to improve these rates and meet the HNJ2020 goals, supporting individual patients and performing home evaluations can improve their targeted treatment regimen. Additionally, ensuring that designated treatment educators are made available to patients, the community and providers at large will allow for sufficient support to a greater range of patients geographically. The following two projects serve to address these issues.

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[13] NJDOH, Asthma Awareness and Education Program (Analysis of 2011 Hospital and ED Files)
[14] NJDOH, "Asthma in New Jersey": http://www.nj.gov/health/fhs/asthma/asthma_resources.shtml#publications
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.

Hospital-Based Educators Teach Optimal Asthma Care

The purpose of this project is to implement a hospital-based asthma educator program in order to provide education to patients, providers and community members on optimum asthma care. In this program, improving training and education is not limited to patient self care. This project is geared to ensure evidence-based training to inpatient providers, as well as education to targeted staff that routinely interact with asthma patients such as childcare centers and schools. This ensures that the community recognizes asthma triggers and supports asthma action plans in order to effectively respond with medication treatment protocols in lieu of exacerbating manageable symptoms.

The goals of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve medication management, and 4) increase patient satisfaction.

Pediatric Asthma Case Management and Home Evaluations

The purpose of this project is to provide case management and home evaluations in an effort to reduce admissions, ED visits and missed school days related to asthma.

The primary component of this project is to support the patient by completing a standardized needs assessment along with a home evaluation where a case manager completes an asthma action plan with the goal to remediate exacerbating environmental triggers. This case management allows for targeted support and linkages of care between primary and specialty care services.

The objectives of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve medication management, 4) reduce missed school days, and 5) improve care processes.

B. Behavioral Health

Of New Jersey's residents, nearly 259,000 adults live with serious mental illness.[20]

National studies estimate that during a one year period up to 30 percent of the US adult population meets criteria for one or more behavioral health diagnoses, particularly mood (19%), anxiety (11%) and substance abuse (25%).[21] Consumers living with serious mental illnesses are dying years earlier than the

[20] National Association of Mental Illness (NAMI) :"NAMI State Advocacy 2010: State Statistics: New Jersey" www.nami.org/ accessed January 31, 2013

[21] NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt

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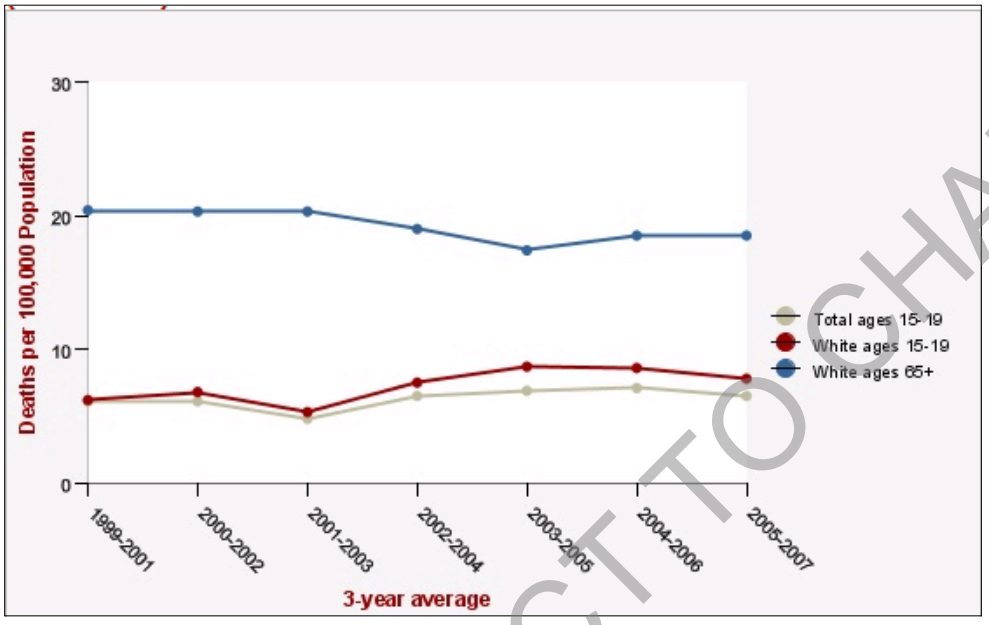
general population, often with unmanaged physical health conditions. The incidence of suicide points to untreated or under-treated mental illness.

Figure V. Suicide Mortality Rate among Males in High Risk Groups, New Jersey, 2000-2007[22]



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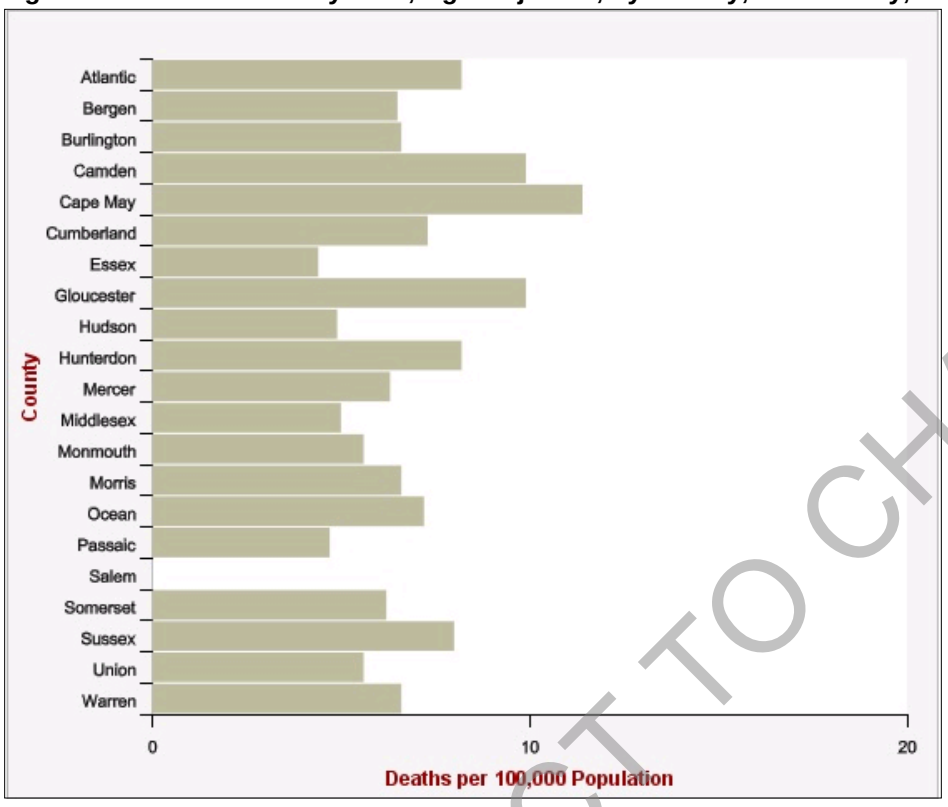
[22] NJDOH, New Jersey State Health Assessment Data, Available at: http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html

Figure VI. Suicide Mortality Rate, Age-Adjusted, by County, New Jersey, 2005-2007[23]



Left untreated, behavioral health problems are associated with considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems and increase healthcare costs. Generally, these individuals use about eight times more healthcare services than the average population. For Medicaid specifically, approximately two-thirds of Medicaid's highest cost adult beneficiaries have a behavioral health diagnosis.[24]

Behavioral health conditions are implicated in all major chronic diseases. Mental health problems are two to three times more common for people with chronic medical illnesses such as diabetes, arthritis, chronic pain, and heart disease. As a result, holistic, condition management is a key feature in the following behavioral health projects.

Integrated Health Home for the Seriously Mentally Ill (SMI)

The objective of this project is to fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.

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[23] NJDOH, New Jersey State Health Assessment Data, Available at: http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html

[24] NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt

Integration will be provided in a client-centered model creating one place to access all services and ensuring patients have ongoing relationships with a medical and psychiatric practitioner. Allowing for all services to be co-located increases the attendance and coordination of needed services. A single treatment plan will be developed with goal setting that includes traditional medication interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching to improve overall health.

As a result, the objectives of the project are to 1) reduce readmissions, 2) reduce emergency department visits, 3) improve patient adherence to their treatment regimen, and 4) improve care processes.

Day Program and School Support Expansion

School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting. This pilot program provides space, therapy and instruction at the hospital's ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Relationships and linkages between the behavioral health provider and the school district are expanded to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses. It is expected with improved support for both the individual and the school, the following objectives will be realized.

These objectives of the project are to 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, 4) improve school education regarding behavioral health programming and referral processes, and 4) lengthen the uninterrupted student tenure within the school setting.

Electronic Self-Assessment Decision Support Tool

The objective of this project is for the hospital to work with outpatient facilities to implement an electronic self-assessment decision support tool to improve the continuum of care treatment provided to mental health patients by improving the efficiency and effectiveness of treatment planning, adherence and communication between the patient and the mental health provider.

This tool should be utilized by patients in the practitioner's office immediately prior to their outpatient mental health visit. The assessment must allow the patient to report on key symptoms and functioning, along with medication

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compliance. The tool must immediately generate a consultation report that both the clinician and the client may refer to during the visit that graphs and trends the key indicators allowing the clinician to quickly identify areas of mental and physical health concern that should be addressed.

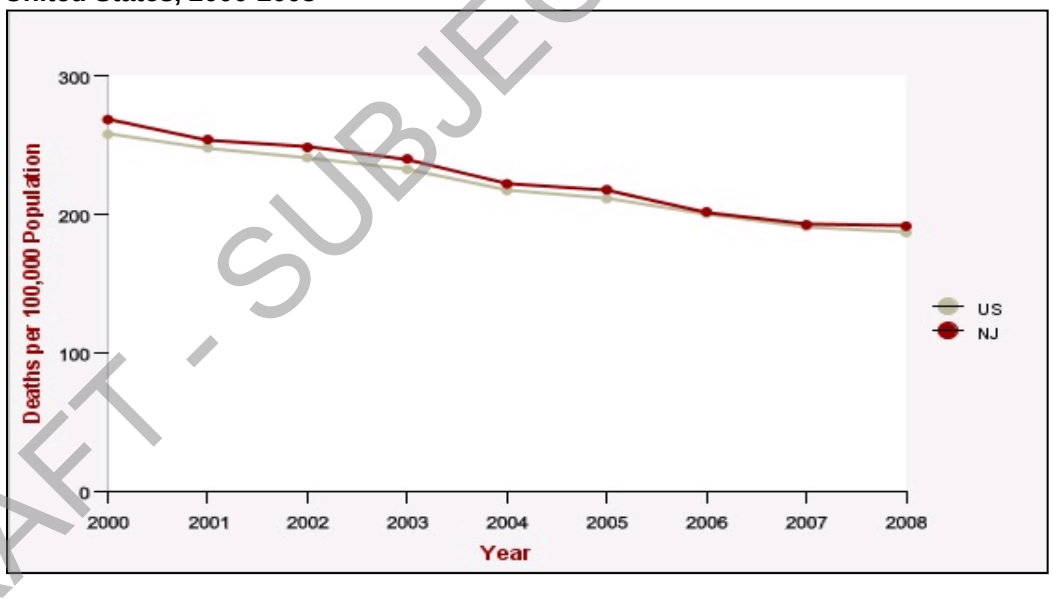
The goals of the assessment report are to 1) reduce readmissions, 2) improve patient-provider communication, 3) increase shared decision-making, 4) improve patient adherence to their treatment regimen, and 4) improve care processes.

C. Cardiac Care

In New Jersey, although age-adjusted mortality rates for heart disease decreased nearly 29% from the year 2000 to the year 2008, heart disease, remained the leading cause of death in 2008[25] among all Americans, all New Jerseyans, men and women. It is the leading cause of death among Whites and Blacks and the second leading cause of death among Hispanics and Asians.

Figure VII below shows the age-adjusted death rate due to heart disease for both the United States and New Jersey between 2000 and 2008. Although there has been a decline over the years, the rate still remains at near 200 deaths per 100,000 population.

Figure VII. Age-Adjusted Death Rate due to Heart Disease by Year, New Jersey and the United States, 2000-2008[26]



Age-adjusted mortality rates for heart disease are:

- Higher for males (242 per 100,000) as compared to females (156)[27] and

[25] NJDOH, "Heart Disease and Stroke in New Jersey"

[26] NJDOH, New Jersey State Health Assessment Data; Available at: http://www4.state.nj.us/dhss-shad/indicator/view/HeartDisDeath.Trend.html

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- Highest for Blacks (225) followed by Whites (196), Hispanics (116) and Asians (84).[28]

Other cardiac related statistics considered included:

- 85% of heart disease and stroke deaths were for residents aged 65 years and older. Estimated lifetime history of cardiovascular disease among adults is[29]:
  - 3.9% for coronary heart disease or angina
  - 3.8% for heart attack
  - 2.4% for stroke

- Estimated prevalence of cardiovascular disease risk factors among adults is[30]:
  - 52.5% for not meeting recommended physical activity levels
  - 37.0% for ever been diagnosed with high cholesterol
  - 30.6% for ever been diagnosed with hypertension
  - 23.7% for obesity
  - 16.8% for current smoking
  - 9.2% for having diabetes

There is a great deal of evidence that indicates that co-morbid and the aging "baby-boomer" populations will continue to drive medical costs in the area of cardiac care. New Jersey has set goals to improve heart health over the course of the next decade. These include moving mortality rates as well as cholesterol checks. The two goals listed in the following table relate to the DSRIP cardiac care projects.

Table IV. HNJ2020 Goals for Cardiac Care Improvement

Goals for Cardiac Care Condition Improvement	
HDS-1: Reduce the death rate due to coronary heart disease	
Target:	112.1 per 100,000 standard population (age-adjusted)
Baseline (Year):	140.1 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
HDS-3: Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years	
Target:	86.7 percent (age-adjusted)
Baseline:	78.8 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

[27] NJDOH, "Heart Disease and Stroke in New Jersey"
[28] NJDOH, "Heart Disease and Stroke in New Jersey"
[29] Ibid.
[30] Ibid.

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The cardiac care projects below seek to improve care coordination, increase consistent evidence-based treatment and improve continuum of care through more supportive patient centered practices in order to improve overall care and treatment in the most appropriate treatment setting.

Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

The purpose of this project is to create an evidence-based Care Transitions Intervention model for cardiac care. This model will focus on the use of hospital Patient Navigators to assist in supporting the patient education process before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications, red-flag indications and how to respond to identified concerns.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

Extensive Patient CHF-focused Multi-Therapeutic Model

The purpose of this project is to decrease the number of readmissions by developing a multi-therapeutic medical home. Nurse practitioners with CHF experience will lead patient education and coordinate home visits to ensure care management.

The goals for this program include 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

The Congestive Heart Failure Transition Program (CHF-TP)

The purpose of this project is to develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.

Through this project, the hospital will incorporate a number of components to ensure a safe patient transition to home or other appropriate health care setting. Key elements include enhanced admission and discharge processes, improved communication and education related to self-care, and the development of a patient centered multi-disciplinary team which effectively completes ongoing medical assessments.

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The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

D. Chemical Addiction/Substance Abuse

Individuals with untreated substance abuse disorders have higher medical costs than those without such disorders, especially for emergency department visits and hospitalizations. Similarly, families of untreated individuals with substance use disorders also have significantly higher medical costs than other families. These family members use up to five times more health care services driven by hospitalizations, pharmacy costs and primary care visits. [31] Reducing the substance use and dependence rate in every county therefore has significant potential to drive health care costs down while improving the long term health outlook for New Jersey families.

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[31] NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt

Table V. Substance abuse and dependence rate per 100,000 population.
Emergency Admissions of Uniform Bill Patients (UB-04) Data, 2009

	Population	Drug Abuse & Dependence		Alcohol Abuse & Dependence	
	2009 [1]	Count	Rate	Count	Rate
ATLANTIC	208,403	1543	740	3280	1574
BERGEN	696,505	1469	211	4648	667
BURLINGTON	343,949	1024	298	1875	545
CAMDEN	392,034	2656	677	2702	689
CAPE MAY	77738	292	376	694	893
CUMBERLAND	118,466	349	295	927	783
ESSEX	576,463	10286	1784	11531	2000
GLOUCESTER	221,209	975	441	1125	509
HUDSON	475,350	1582	333	6837	1438
HUNTERDON	99346	197	198	548	552
MERCER	282,357	1567	555	3328	1179
MIDDLESEX	606,496	1752	289	3886	641
MONMOUTH	490,164	2445	499	3919	800
MORRIS	371,762	853	229	2323	625
OCEAN	441,732	2814	637	3656	828
PASSAIC	367,358	1577	429	3708	1009
SALEM	50752	244	481	208	410
SOMERSET	246,132	606	246	1354	550
SUSSEX	115,303	392	340	687	596
UNION	396,925	1488	375	3331	839
WARREN	83983	229	273	481	573
New Jersey	6,662,427	**34340**	**515**	**61048**	**916**

[1] Source: U.S. Census Bureau, Population Estimates Program, July 1, 2009.
Prepared by: Office of Research, Planning, Evaluation, Information Systems and Technology
Division of Addiction Services, New Jersey Department of Human Services

The complications related to addiction and abuse for self-management cause an important need for overall health management support. Ensuring medical management screenings and treatment for addiction allows improved whole person care. The following projects strive to ensure more immediate symptomatic treatment for withdrawal and a pathway to long term treatment and recovery.

Hospital-Wide Screening for Substance Use Disorder

The objective of this project is to ensure the utilization of hospital-wide screening tools to detect alcohol or substance withdrawal for all patients admitted to the

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hospital regardless of the admitting diagnosis or event in order to effectively manage these symptoms. Upon screening, precautionary or treatment algorithms will be initiated as needed. Proper identification of withdrawal symptoms allows management of the symptoms prior to more serious complications.

The objectives of this project are to 1) decrease length of stay, 2) decrease use of restraints, 3) decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU), 4) increased referral/ admissions to substance abuse treatment programs/ facilities, and 5) improve care processes.

Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients

The purpose of this project is to offer an alternative treatment setting for acute alcohol intoxicated patients in order to lower the emergency department length of stay and offer immediate access to treatment.

This project requires a partnership between emergency departments and addiction service providers in order to allow stabilized patients suffering from acute intoxication to be transferred to a treatment setting.

The objectives for this project include 1) lower emergency department length of stays for intoxicated patients, 2) increase referral/ admissions to substance abuse treatment programs/ facilities, and 3) improve care processes.

E. Diabetes

In New Jersey, diabetes is not only common, it is also costly and significant in its impact on health. Diabetes was the sixth leading cause of death in 2008 and about 77% of diabetes-related deaths were for residents aged 65 years and older.[32]

Figure VIII below shows the age-adjusted death rate due to diabetes for both the United States and New Jersey between 2000 and 2008. Over the years, the rate has declined for both New Jersey and the United States; however the rate continues to be more than 20 deaths per 100,000 population for this manageable condition.

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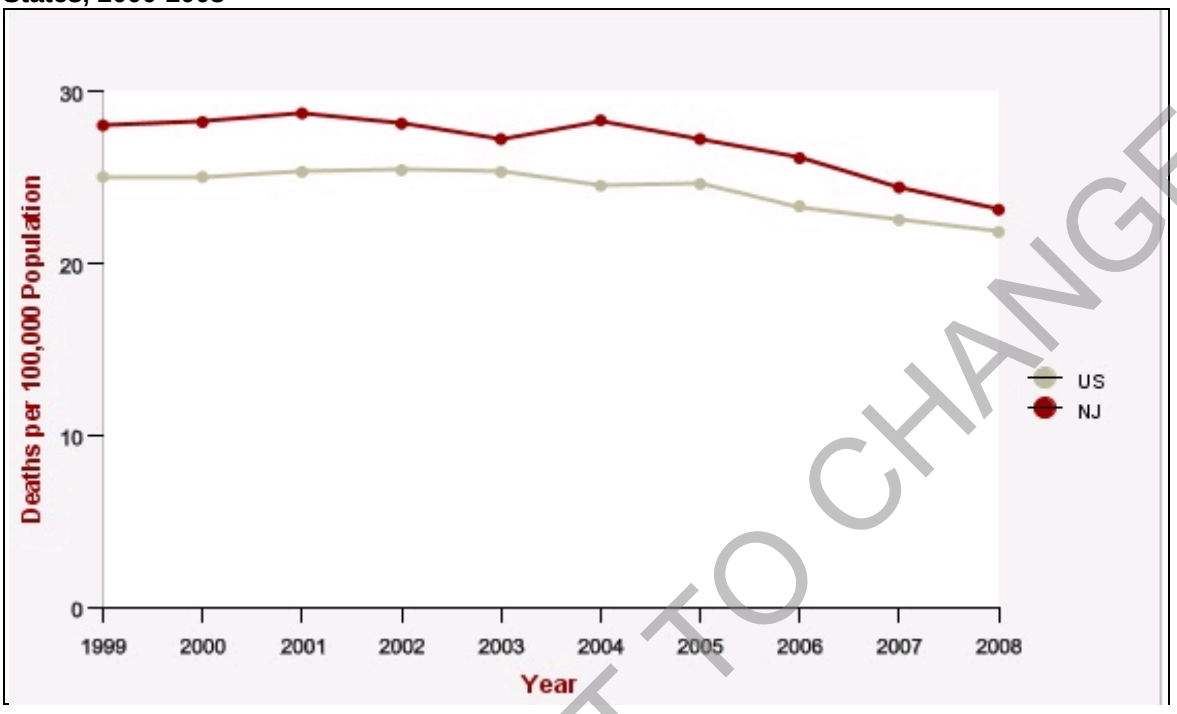
[32] New Jersey Death Certificate Database, NJDOH, Center for Health Statistics, New Jersey State Health Assessment Data: http://nj.gov/health/shad

Figure VIII. Age-Adjusted Death Rate due to Diabetes by Year, New Jersey and the United States, 2000-2008[33]



Other diabetes related statistics considered included:

- Age-adjusted prevalence estimate for adults increased from 4.3% in 1993 to 8.3% in 2010.[34]
- About 9.2% of adults have diabetes. Diabetes prevalence estimates for adults are[35]:
  - Highest for 65 years and older (21.5%) and lowest for 18-24 years (1.4%)
  - Highest for Black (15.4%) followed by Hispanic (9.5%), and then White (8.1%)
  - Highest in the lowest income households of less than $15,000 annually (15.1%)
  - Highest for those who did not graduate high school (18.0%)
- Among adults with diabetes[36] approximately:
  - 65.4% were ever diagnosed with hypertension
  - 54.7% were ever diagnosed with high cholesterol
  - 47.5% are obese
  - 13.6% are current smokers
  - 72.5% had two or more A1c tests in the prior year
  - 71.8% had a dilated eye exam in the prior year

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[33] http://www4.state.nj.us/dhss-shad/indicator/view/DiabetesDeath.Trend.html
[34] NJDOH, "Diabetes in New Jersey"
[35] Ibid.
[36] Ibid.

- 68.1% had a foot exam in the prior year
- 59.9% perform daily self-monitoring of blood glucose
- 58.1% received an influenza immunization in the prior year
- 48.1% ever received a pneumococcal immunization
- 42.3% ever attended a diabetes self-management class

- In 2009, a total of 1,520 adults began treatment for diabetes-related end-stage renal disease.[37]

As described in the HNJ2020, the goals set for diabetes improvement include:

Table VI. HNJ2020 Goals for Diabetes Improvement

Goals for Diabetes Improvement	
DM-1: Reduce the death rate due to diabetes	
Target:	15.8 per 100,000 standard population (age-adjusted)
Baseline (Year):	24.4 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
DM-2: Reduce the rate of lower extremity amputations in persons with diagnosed diabetes	
Target:	28.6 per 1,000 persons diagnosed with diabetes
Baseline (Year):	31.8 per 1,000 persons diagnosed with diabetes (2009)
Data source:	Uniform Billing Patient Summary Data, Office of Health Care Quality Assessment, New Jersey Department of Health
DM-3: Increase the proportion of adults with diabetes who have an annual dilated eye examination	
Target:	72.2 percent (age-adjusted)
Baseline(Year):	65.6 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
DM-4: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (AC1) at least twice a year	
Target:	59.4 percent (age-adjusted)
Baseline (Year):	54.0 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

Finding better and consistent methods to increase patient self care and training is critical to managing this chronic condition.

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[37] Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: http://www.cdc.gov/diabetes/statistics. Retrieved [01/16/2013]

Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension

The purpose of this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.

The goals are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

Diabetes Group Visits for Patients and Community Education

The purpose of this project is first, to ensure that all newly diagnosed diabetic patients have a clear understanding of their plan of care. Second, that patients are knowledgeable regarding expected outcomes and disease management and third, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.

The goals of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

Develop Intensive Case Management for Medically Complex High Cost Patients

The purpose of this project is to reduce inpatient admissions and ED visits for the most costly medically complex patients with a primary diagnosis of diabetes through an intensive case management and care coordination program. This program assigns each enrolled patient to a physician-led team of multi-therapeutic providers. This team is available to help the individual navigate the health care system, access available financial assistance and utilize appropriate community resources.

The goals are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

F. HIV/AIDS

In 2012, 36,192 people were reported living with HIV or AIDS in New Jersey.[38] The data indicates that:

- Minorities account for 76% of adult/ adolescent cumulative (reported to the state) HIV/AIDS cases and 77% of all persons living with HIV/AIDS.[39]

[38] NJDOH, "New Jersey HIV/AIDS Report, June 30, 2012": http://www.state.nj.us/health/aids
[39] Ibid.

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- Seventy-nine percent (79%) of those persons living with HIV/AIDS are 40 years of age or older.[40]
- Injection drug use and sexual contact remain the major modes of exposure to HIV infection. The proportion of reported cases with HIV/AIDS who were exposed through injection drug use (IDU) is lower than in the past, while the proportion of cases that were exposed through sexual contact is increasing.[41]

Table VII. New Jersey Residents Living with HIV/AIDS as of June 30, 2012 Racial/Ethnic Group by Gender[42]

	MALE		FEMALE		TOTAL		% of Prevalent Cases Who Are Female
Race/Ethnicity	No.	%	No.	%	No.	%	
White	6,032	25%	1,937	16%	7,969	22%	24%
Black	11,550	48%	7,805	63%	19,355	53%	40%
Hispanic	5,818	24%	2,447	20%	8,265	23%	30%
Asian/Pac. Isl.	283	1%	101	1%	384	1%	26%
Other/Unknown	141	1%	78	1%	219	1%	36%
Total	23,824	100%	12,368	100%	36,192	100%	34%

Note: Percentages may not add to 100 due to rounding.

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[40] NJDOH, "New Jersey HIV/AIDS Report, June 30, 2012": http://www.state.nj.us/health/aids
[41] Ibid.
[42] Ibid.

As described in the HNJ2020, some of the goals set for HIV/AIDS improvement include:

Table VIII. HNJ2020 Goals for HIV/AIDS

Goals for HIV/AIDs Improvement	
HIV-1: Reduce the rate of HIV transmission among adolescents and adults	
Target:	12.5 per 100,000 population
Baseline (Year):	15.6 per 100,000 population (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
HIV-2: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	
Target:	65 percent
Baseline (Year):	54 percent (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
HIV-3: Reduce the death rate due to HIV infection	
Target:	4.2 per 100,000 standard population (age-adjusted)
Baseline (Year):	5.3 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health

As new therapies become available, a larger percentage of patients will remain HIV positive for longer periods of time before developing AIDS. Ensuring that these patients are managed effectively is important to reduce incidence and prevalence of exposure. This population is dealing with complex social issues and medication regimens due to their illness, however with effective support, the condition can be managed by improving the overall quality of life for people living with HIV/AIDS. This project is geared to assisting the individual patient and the community at-large.

Patient Centered Medical Home for Patients with HIV/AIDS

The objective of this project is to develop and implement a patient centered medical home for patients with HIV ensuring interdisciplinary outpatient management, intensive hospital discharge planning, and dedicated patient navigation services to ensure the receipt of optimal social services.

With increased support, it is expected that these objectives will be met: 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, and 4) increase patient satisfaction.

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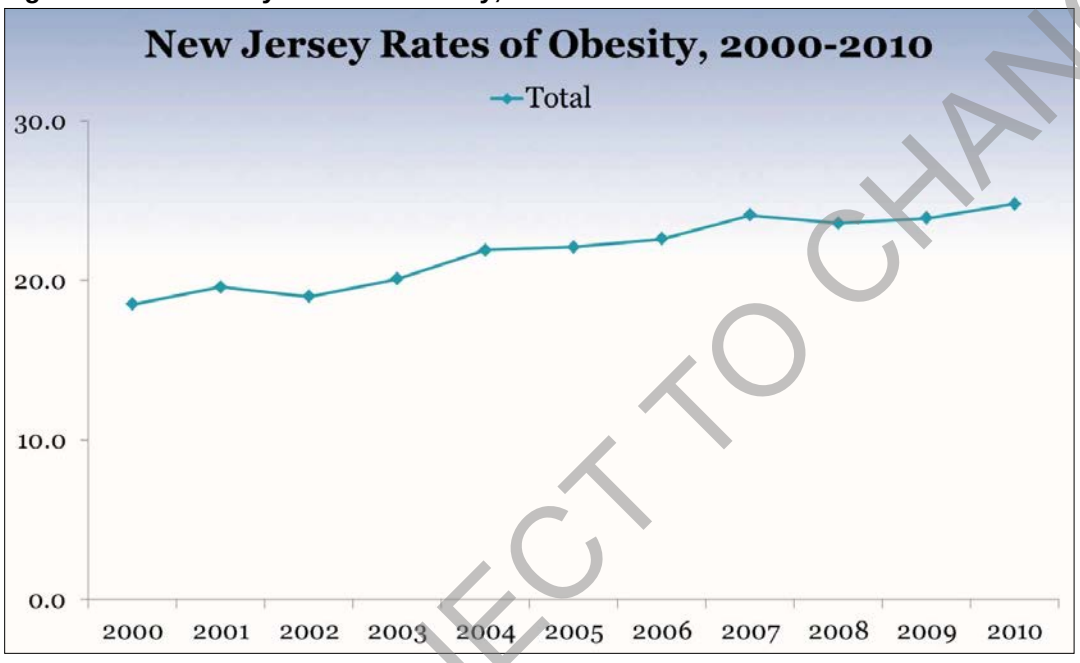
G. Obesity

Nearly one out of four (23.7%) New Jersey adults are obese.[43] As shown in Figure IX, over the last 10 years, rates of adult obesity increased 40%[44].

Figure IX. New Jersey Rates of Obesity, 2000-2010



Particularly New Jersey counties, Salem (33.8%), Cumberland (33.2%), and Atlantic (28.0%), have the highest rates of adult obesity in New Jersey while Hunterdon (20.5%), Somerset (21.3%), and Monmouth (21.3%) counties have the lowest rates[45].

If obesity rates continue to increase at their current pace, nearly half (48.6%) of New Jersey adults will be obese in 2030. Unfortunately, New Jersey has one of the three highest obesity rates in the nation among low-income children, ages 2-5 (16.5%). [46]

Nearly one out of three (31%) children, ages 10-17 are overweight or obese in New Jersey. Eleven percent (11%) of New Jersey high school students are obese[47]. Today's childhood obesity rates are putting New Jersey children on course to be the first generation in this country to live shorter and less healthy lives than their parents.

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[43] NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet"
[44] Ibid.
[45] NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet"
[46] Ibid.
[47] Ibid.

In 2008, New Jersey spent $2.2 billion on obesity-related health care. If obesity rates continue to increase, New Jersey's obesity-related healthcare spending will quadruple to $9.3 billion by 2018.[48]

As indicated in the HNJ2020, some of the New Jersey goals in this topic area, shown in Table IX below, include ensuring that these target rates move or continue to match the benchmark.

Table IX. HNJ2020 Goals for Obesity

Goals for Obesity Condition Improvement	
NF-1: Prevent an increase in the proportion of the population that is obese	
NF-1a: adults aged 18 years and older	
Target:	23.8 percent
Baseline (Year):	23.8 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-1b: high school students (grades 9-12)	
Target:	10.3 percent
Baseline (Year):	10.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-2: Increase the proportion of the population consuming five or more servings of fruits and vegetables per day	
NF-2a: adults aged 18 years and older	
Target:	28.7 percent
Baseline (Year):	26.1 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-2b: high school students (grades 9-12)	
Target:	22.1 percent
Baseline (Year):	20.1 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-3: Increase aerobic physical activity	
NF-3a: Proportion of adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity	
Target:	58.5 percent (age-adjusted)
Baseline (Year):	53.2 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

[48] NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet"

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Goals for Obesity Condition Improvement	
NF-3b: Proportion of high school students that meet current physical activity guidelines for moderate or vigorous physical activity	
Target:	23.4 percent
Baseline (Year):	21.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education

The following DSRIP projects are primarily geared to children and developing healthy habits for those less than 18 years of age in New Jersey.

After School Obesity Program

The purpose of this project is to develop community partnerships to create school-based wellness programs for overweight children. The program is to provide education, exercise and medical services, such as targeted screenings (e.g. cholesterol and lipid screening, hypertension screening) by licensed practitioners.

The goals for this project are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and 3) improve care processes.

Wellness Program for Parents and Preschoolers

The purpose of this project is to develop a wellness program to help obese preschoolers and overweight parents improve eating habits and reduce body mass index. The program consists of alternating group-based sessions and in-home, one-on-one consultations.

The goals are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and improve care processes.

H. Pneumonia

Influenza and pneumonia combined are the tenth leading cause of death among New Jersey residents. Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Vaccination against pneumococcal disease has been effective in reducing infections among seniors and persons with medical conditions. Table X provides an overview of how New Jersey performed from years 2006-2010 for several quality measures for pneumonia care from 2006-2010.

DRAFT - SUBJECT TO CHANGE

Table X. New Jersey Hospital Quality Scores

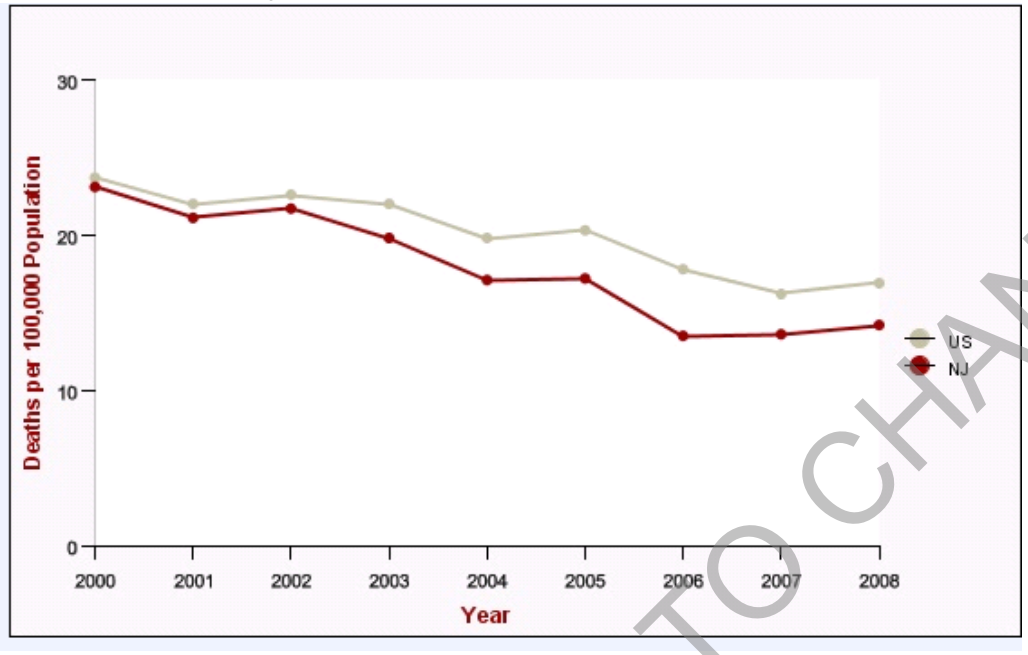
QUALITY MEASURE	2006	2007	2008	2009	2010
PNEUMOCOCCAL VACCINATION	87	91	93	95	96
ANTIBIOTIC SELECTION	89	92	92	94	95
ANTIBIOTIC TIMING			95	96	97
BLOOD CULTURES	94	94	95	97	97
SMOKING CESSATION ADVICE	94	96	97	99	100
INFLUENZA VACCINATION		87	90	93	95

The age-adjusted death rate due to influenza and pneumonia for both the United States and New Jersey between 2000 and 2008, shown in Figure X below, has declined over the years, but New Jersey continues to look for ways to decrease this rate. Current measurement results indicate that the New Jersey influenza and pneumonia death rate of 11.0 was below the United States average of 15.1 per 100,000. However, this rate reflects 1,128 deaths which suggests that more can be done.[49]

DRAFT - SUBJECT TO CHANGE

[49] National Vital Statistics System, www.cdc.gov/nchs/pressroom/stats/FLU_PNEUMONIA_STATE_2010.pdf .

Figure X. Age-Adjusted Death Rate due to Influenza and Pneumonia by Year, New Jersey and the United States, 2000-2008[50]



The following project will work towards improving recommended pneumonia care.

Patients Receive Recommended Care for Community-Acquired Pneumonia

The purpose of this project is to ensure that patients with community-acquired pneumonia (CAP) receive recommended care as measured by the Joint Commission/CMS Pneumonia Core Measure Set. A multi-therapeutic workgroup will ensure the implementation of standardized order sets for both the emergency department and the inpatient setting to ensure a consistent, evidence-based care approach.

The objectives are expected to 1) reduce readmissions, 2) decrease length of stay for Community-Acquired Pneumonia (CAP), and 3) improve care processes.

VI. Stage 3 Measures (Project-Specific Metrics)

As noted above, it is the goal of the DSRIP program to positively affect the health outcomes for all New Jersey residents. In order to monitor the performance of the DSRIP projects, a set of clinical process and outcome measures have been chosen that can demonstrate measureable improvement towards meeting the project objectives. Stage 3 of the DSRIP program focuses on measuring this improvement.

[50] NJDOH, New Jersey Health Assessment Data; Available at: http://www4.state.nj.us/dhss-shad/indicator/view/PneuFluDeath.Trend.html

DRAFT - SUBJECT TO CHANGE

Stage 3 metrics have been selected based on nationally recognized measurements related to the project condition. The metrics chosen are recognized by national bodies including the American Academy of Pediatrics, the American Medical Association, the National Committee on Quality Assurance (NCQA) and the National Quality Forum (NQF).

The Stage 3 measures that will be collected are listed in Addendum 1 of this protocol.

In order to determine the performance of Stage 3 measures, data capture of medical record charts, electronic health records, or data captured and submitted on a claim to the state's Medicaid Management Information System (MMIS) may be required. To support efficient analysis of performance reporting, the Department will calculate the performance rate for measures that utilize claims-based data. It will be the responsibility of the hospital, to capture and submit all other measures. The baseline performance periods for each Stage 3 measure will be based on the measure's technical specifications and will be detailed in a measurement databook that will be developed and made available to the hospitals in the toolkit no later than November 15, 2013.

However, it is expected that for any Stage 3 measure that is currently being collected by the hospital, that baseline data be supplied with the submission of the DSRIP application. For any data that is not currently being collected, the hospital will be required to submit a plan outlining the means and timeline to collect and submit the data per the reporting requirements described in Attachment 1: DSRIP Toolkit.

Payment for reporting all measures will occur during demonstration years 2 and 3. Certain Stage 3 measures will be tied to pay for performance (P4P) (e.g. pay for improvement) incentive payments during demonstration years 4 and 5 as outlined in the Funding and Mechanics Protocol (FMP).

VII. Stage 4 Measures (Universal Metrics)

The purpose of this section is to specify a set of Stage 4 measures that must be collected and reported by all hospitals regardless of the specific project that they choose to undertake. A catalogue of the Stage 4 measures is included in Addendum 2 to this protocol.

It is expected that for any universal Stage 4 measure currently being collected, baseline data will be supplied with the submission of the DSRIP application. For any data that is not currently being collected, the hospital will be required to submit a plan outlining when the hospital will be able to collect and submit the data per the reporting requirements described in the DSRIP Toolkit. The baseline

DRAFT - SUBJECT TO CHANGE

performance periods for each Stage 3 measure will be based on the measure's technical specifications and will be detailed in a measurement databook that will be developed and made available to the hospitals in the toolkit no later than November 15, 2013.

Funding will be tied to the reporting of Stage 4 measures throughout the demonstration period as outlined in the Funding and Mechanics Protocol (FMP). Hospitals may be able to obtain additional funding through the Universal Performance Pool for certain Stage 4 measures, also outlined in the FMP.

A. Attribution

Performance measurement for both Stage 3 and 4 metrics will measure improvement for specified population groups, including the Charity Care, Medicaid and CHIP populations, collectively referred to as the Low Income population.

An attribution model to link the Low Income (Charity Care, Medicaid and CHIP) population with DSRIP project partners for Stage 3 and 4 performance measurement will be developed by the Department with the input and support by the hospital industry.

The Low Income attribution model will be based on one of the following models:

a) The CMS Pioneer Accountable Care Organization (ACO) Program or Medicare Shared Savings Program, if suitable using MMIS data
b) An ACO model if operational at a NJ hospital system or Medicaid Managed Care Organization (MCO)

This model will be submitted to CMS by September 30, 2013, 2013 for review and approval by CMS by October 14, 2013.

VIII. Requirements of the Hospital DSRIP Plans

This section details the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g) of the STCs.

A. DSRIP Plans

Each hospital that elects to participate in the DSRIP program must submit a Hospital-specific DSRIP Plan using a Department approved application that identifies the project, objectives, specific milestones, and metrics and meets all requirements pursuant to the STCs. The following provides a description of the organizational structure of the DSRIP Plan.

i. General Requirements

Hospitals will first select one of the nine focus areas. The focus areas are:

DRAFT - SUBJECT TO CHANGE

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addiction/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia
- A medical condition unique to the hospital

CMS approval will be required for all hospital unique focus areas.

Once the focus area is determined, the DSRIP participating hospital will choose a project from the project array for the focus area selected. The hospital will then select activities from a pre-determined menu of activities related to the development and implementation of the project. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities.

As stated before, hospitals may select an "off-menu" or "unique" project related to the focus area selected, however, this project will be need to be completely developed by the hospital and will be subject to higher levels of scrutiny and review by the Department and CMS during the approval process and include the justifications described in Section V.

ii. *Framework for the Development of the Hospital DSRIP Plan (i.e. Hospital DSRIP Plan Template)*

The Hospital DSRIP Plan Template included in Attachment 1: DSRIP Toolkit, Section IV. provides a framework for each DSRIP Project and the development of the hospital's DSRIP Plan. It includes several required elements, including those described below in the Executive Summary and Other DSRIP Plan Required Components. The Hospital DSRIP Plan Template includes the menu of activities, the associated actions/milestones, the associated metrics, and the minimum submission requirements. It also provides guidance to the hospitals as to when each activity is expected to be completed.

iii. *High Performing Hospitals - Baseline Performance Threshold*

It is the expectation of the Department and CMS that a hospital select a project for which substantial need for improvement in the Focus Area is reflected. Therefore, for each Stage 3 pay for performance metric, a baseline performance threshold will be established in order to determine if a hospital can use the metric for pay for performance payments. The performance threshold is calculated using baseline data.

DRAFT - SUBJECT TO CHANGE

This baseline performance threshold will be calculated at:

- the lower of 20 percentile points below the metric's high performance level (improvement target goal), based on New Jersey hospital's data, *or*
- 20 percentile points below the 95th percentile of national performance data, if national data is available for the low income population.

For example, if the metric's improvement target goal is the 90th percentile, the metric's baseline performance threshold will be set at the 70th percentile (90th percentile – 20 percentile points = 70th percentile). However, there will be no minimum performance cut-off for low performance on these metrics.

If a hospital's metric baseline year performance for any given Stage 3 pay for performance measure exceeds the metric's baseline performance threshold, the following rules will apply:

a. *Exceeds All Measures* –
   - *Non-cardiac project* - If a hospital exceeds the performance threshold for all project-specific Stage 3 pay for performance measures for a non-cardiac project at baseline, the hospital will be required to select a different project.
   - *Cardiac project* - If the hospital exceeds the performance threshold for all project-specific Stage 3 pay for performance measures for a cardiac care project at baseline, the hospital may either (1) select a different project, or (2) substitute an equal number of measures from the Million Hearts Campaign. These are to be selected based on which of the hospital's baseline performance among New Jersey hospitals is lowest in terms of percentile, and consistent with (iii.d.) below.

     From the time the hospital is notified it exceeds all Stage 3 measures until a new project application or project expansion is approved by the Department and CMS, the hospital will receive no DSRIP payments.

b. *Exceeds Multiple Measures* -
   - If a hospital exceeds the performance threshold for more than one project-specific pay for performance measure, but not all project-specific P4P measures, the hospital will be required to substitute measures as provided under item (iii.d.) below.

     Also, as part of its next required quarterly report, the hospital will be required to document the project integrity including the applicability of Stage 1 and Stage 2 activity plans and additional measures the hospital will institute to measure project improvement.

DRAFT - SUBJECT TO CHANGE

c. *Exceeds a Single Measure* –
   - If a hospital exceeds the performance threshold for only one project-specific pay for performance measure, the hospital will have the option of (1) receiving payment using one less measure, or (2) substituting the measure as provided under item (iii.d.) below provided the hospital has at least two Stage 3 P4P measures.

d. Measure substitution:
   - *Non-cardiac project* - For projects other than cardiac care projects, the substitution measure may be either:
     - The hospital's lowest performing Stage 4 metric, *or*
     - Other outcomes metrics, as recommended by the Quality & Measures Committee and as approved by the Department and CMS. The hospital's baseline performance for this substitution metric must be lower than the measure's baseline performance threshold.
   - *Cardiac project* - Hospitals who selected a cardiac care project must select from one of the Million Hearts metrics where the hospital's baseline performance is lower than the metric baseline performance threshold for the given Million Hearts metric.

e. *Reinstatement of Stage 3 Pay for Performance Measure* - For any performance metric where the performance was higher than the metric's Baseline Performance Threshold at the baseline and substitution occurred, but later the hospital regresses on the measure to below the Baseline Performance Threshold, pay for performance for the measure may apply the following demonstration year.

For reference to the improvement target goal calculation please review the Funding and Mechanics Protocol Section VII.B.

iv. Executive Summary

The Executive Summary shall provide a summary of the hospital's DSRIP Plan, including a description of the health system, a description of the hospital's patient population and a description of the hospital's vision of delivery system transformation. It shall also describe the significance of the project as it relates to the hospital, and the community, share key challenges facing the hospital, and convey how the DSRIP Plan realizes the hospital's vision and mission.

a. Significance

As part of this subsection, each hospital will provide the rationale for selecting the project and project activities based on the significance to the population their hospital serves and their community needs as determined through a community needs assessment. The hospital must show how the project will measurably improve health for their

DRAFT - SUBJECT TO CHANGE

patient population, how the activities selected will demonstrate improvement, and how the DSRIP project they selected is consistent with their hospital's mission, quality goals and the Department's DSRIP vision.

The community needs assessment should consider the greater needs of the community. It should include the following elements:

- Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
- Description of the current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA], federally qualified health centers, state funded health centers, department of health facilities, health care for the homeless)
- Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care)
- Description of changes in the above areas that are expected to occur during the waiver period
- Key health challenges specific to the hospital's surrounding area supported by data (e.g., high diabetes rates, access issues, high emergency department utilization, etc.)
- Description of how hospitals will include and/or coordinate with their local health officials in the DSRIP project and community needs assessment. The Department strongly encourages collaboration between participating hospitals and public health.

The participating hospital's community needs assessment should guide the selection of a project and be reflected in the DSRIP Plan. The community needs assessment may be compiled from existing data sources.

b. *<u>Challenges</u>*

Participating hospitals are required to describe the current and expected challenges or issues the hospital faces or will face while implementing their project. Hospitals will also need to include a brief description of the delivery system solution identified to address those challenges. If one of the hospital's challenges is that it cannot provide all or part of the baseline data requirement, the hospital will be required to describe in this section, the hospital's plan, including a timeline, for implementing the necessary means for obtaining and submitting the baseline data to the Department.

c. *<u>Starting Point</u>*

The starting point should include the identification of project needs, such as funding, data, members of the project plan, etc., and how those needs will be met to begin the project. Participating hospitals must demonstrate whether the project is a new initiative for the

DRAFT - SUBJECT TO CHANGE

hospital, or significantly enhances an existing health care initiative. Hospitals must identify all parts of the DSRIP project currently or expected to be funded by other CMS, U.S. Department of Health and Human Services (HHS), or other government funded initiatives in which they participate. The hospital must explain how their proposed DSRIP activities are not duplicative of the activities already funded or expected to be funded in the future.

d. *Public Input*

The Hospital-specific DSRIP Plan shall include a description of the processes used to engage the following stakeholders:

- Hospitals and other providers in the region
- Local public health departments. Hospitals must consider local public health departments as part of the public input process
- Public stakeholders and consumers
- Any other project stakeholders identified by the hospital

At a minimum the processes used to solicit public input should include a description of public meetings that were held, the process for receiving public comment on the hospital DSRIP plan, and a plan for ongoing engagement with public stakeholders (including the Quality & Measures Committee described in Section IX).

Each project in New Jersey's DSRIP project array generally identifies the population-focused objectives, the methodology by which the hospital will conduct the project, and anticipated outcomes of the project. As outlined in the Hospital DSRIP Plan Template, the hospital will be required to identify each elective stage activity and when the elective and required activities will be completed in the demonstration. For each activity, hospitals will also be required to include its hospital-specific objectives, methodologies, and goals/outcomes.

v. Other DSRIP Plan Required Components

As part of the DSRIP Plan, the DSRIP application will require hospitals to identify several key program components that will be needed for Stage 1 Infrastructure Development. These include conducting a gap analysis, identifying partners, identifying the target population, and identifying interventions.

The menu of pre-defined project activities includes the required steps to develop and implement the hospital's project plan. In the application, hospitals will be required to prepare for key project components such as the identification of the multi-therapeutic medical and social support team needed, staff education needs, technical needs, logistical and supply needs, data needs, and marketing/outreach needs. Stage 1 activities will be related to procuring these needs.

DRAFT - SUBJECT TO CHANGE

The menu of activities includes the quality improvement interventions required to achieve the outcomes of the project (e.g. improving treatment protocols, discharge planning and care transitions, instituting population registries and case management systems, developing patient centered and integrated medical/ behavioral health homes).

vi. Milestones and Metrics Table

The DSRIP Plan will indicate by demonstration year when project activities and milestones will be achieved and indicate the data source that will be used to document and verify achievement.

- Hospitals must select a minimum of 7 activities from Stage 1.
- Hospitals will complete all of the defined activities in Stage 2.
- Stage 3 and Stage 4 activities consist of reporting the project-specific metrics and the universal metrics, respectively. Hospitals will be required to report these metrics throughout the demonstration period. Funding for this activity is based on reporting and/or meeting improvement targets. Further detail on how this reporting activity ties to funding is included in the FMP.

B. Project Activities, Milestones, and Metrics

The DSRIP Plan will include sections for each of the 4 stages specified above in Section IV. Project Stages. The following are the requirements for the DSRIP application and each of the four stages.

i. Stage 1 Requirements: Infrastructure Development

Stage 1 involves procuring the necessary resources identified in the application and the infrastructure needed to conduct the project.

ii. Stage 2 Requirements: Chronic Medical Condition Redesign and Management

Stage 2 involves activities related to piloting the project to the hospital selected pilot population, as well as re-designing the project based on the results of the pilot. All Stage 2 activities, identified in the Hospital DSRIP Plan Template (Attachment 1: DSRIP Toolkit), are required.

iii. Stage 3 Requirements: Outcome Reporting and Quality Improvements

Stage 3 involves the monitoring of project-specific clinical measures that are associated with the achievement of implementing Stage 1 and 2 project activities and meeting milestones. All participating hospitals shall report these project-specific outcomes in each demonstration year at a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines.

DRAFT - SUBJECT TO CHANGE

Improvement target goals for selected measures will be established based on the methodology described in the FMP. The metrics shall assess the results of care experienced by patients, including patient's clinical events, patient's recovery and health status, patient's experiences in the health system, and efficiency/cost.

As part of the DSRIP Plan application, hospitals are required to submit baseline data for each project-specific metric that is the responsibility of the hospital (e.g. non-claims based measure). If the hospital is unable to provide baseline data at the time of application due to a lack of infrastructure, the hospital will be required to describe the hospital's plan, including a timeline, for implementing the infrastructure to obtain the data. Such baselines must be established no later than DY 3.

iv. Stage 4 Requirements: DSRIP Performance Indicators (i.e. Universal Metrics)

Pursuant to the STCs, hospitals will be required to report DSRIP performance indicators as a Stage 4 activity. These universal metrics will be reported across several domains selected by the Department based on community readmission rates and hospital acquired infections. DSRIP performance indicators will be connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. In accordance with this requirement, by the end of DY 3, hospitals must include reporting of all defined DSRIP universal metrics.

In addition to reporting and payment of Stage 4 measures, hospitals will be eligible to receive payments for a core set of Stage 4 measures through a financial performance pool. The Universal Performance Pool (UPP) rewards hospitals that maintain, or improve hospital performance across a broad spectrum of critical domains of inpatient care. The measures eligible for this pool are denoted in the Addendum 2: Stage 4 Measures Catalogue.

IX. Quality & Measures Committee (Committee)

The Department will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

DRAFT - SUBJECT TO CHANGE

Final decision-making authority will be retained by the Department and CMS, although all recommendations of the committee will be considered by the Department and CMS.

Specifically, the Quality & Measures Committee will provide feedback to the Department regarding:

- Development of the Low income attribution model
- Selection of additional metrics for hospitals who have reached the Metric Baseline Performance Threshold
- Selection of the Improvement Target Goal for Stage 3 performance metrics tied to incentive payments

A. Composition of the Committee

The membership of the committee shall consist of between seven and nine members with no more than three members employed by New Jersey hospitals. All members will be appointed be the Commissioner of Health based on the following composition criteria:

- Representation from community health centers serving the low income population.
- Several members shall be clinical experts in one of the following specialty care areas: Behavioral Health, Cardiology, HIV/AIDS, Pulmonology, and Primary Care. Clinical experts are physicians, physician assistants, nurse practitioners, and registered nurses.
- At least two members shall have significant expertise in clinical quality measurement of hospitals. Significant expertise is defined as not less than five years of recent full time employment in quality measurement in government service or from companies providing quality measurement services to hospitals.
- A member from the New Jersey Hospital Association, the largest trade association in New Jersey, with current expertise and engagement in quality management services provided to New Jersey hospitals.
- A member as a consumer.

X. DSRIP Program Performance Management

Performance management and assessment of the DSRIP program will occur throughout the duration of the waiver and will take on several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning.

DRAFT - SUBJECT TO CHANGE

1) A formative evaluation of DSRIP will occur on a regular basis which seeks to provide timely and actionable feedback on the initiative's progress, in terms of both implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, progress towards achieving a health care system based on the Triple Aim, and progress toward achieving the primary goals of DSRIP.
2) Learning collaboratives will be implemented to seek peer-to-peer (hospital-to-hospital) input on project level development of action plans, implementation approaches and project assessment. The Department will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results).
3) A mid-point assessment of DSRIP will be completed by the independent DSRIP evaluator to provide broader learning both within the state and within the national landscape. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.
4) A final summative assessment of DSRIP will be completed by the independent DSRIP evaluator describing changes in quality and access outcomes resulting from DSRIP, as well as other outcomes of interest and identifying the changes in outcomes resulting from transformation activities.

A. New Jersey DSRIP Performance Management

The Department, or its designee, will conduct robust monitoring and assessment of all submitted reports, hospital progress, challenges and completion no less frequently than quarterly, and as appropriate in order to monitor DSRIP implementation and activities.

Upon this review, an analysis will be made regarding:

- the extent of progress each hospital is making towards meeting each milestone
- the specific activities that appear to be driving measureable change
- the key implementation challenges associated with specific activities designed to drive improvement
- the identification of adjustments to the DSRIP program, and/or projects as observed through the analysis of submitted hospital-level data and/or onsite findings as they occur

Comparative analysis and findings will be performed and summarized into actionable reports that provide the right level of information to various program stakeholders to help facilitate learning at the hospital level, as well as the DSRIP

DRAFT - SUBJECT TO CHANGE

program level. The reports will be used to drive peer-to-peer hospital discussion regarding opportunities for improvement and methods for course correction through the use of the Learning Collaborative. The results of these assessments will be disseminated to the independent DSRIP evaluation contractor and CMS. This information is expected to inform the DSRIP evaluation during both the mid-point and summative evaluations to understand key factors related to the performance and progression of the DSRIP program to date.

The Department, or its designee, will take effective action, as needed, to remedy a finding to promote fulfillment of the DSRIP goals. This may include providing feedback to the hospital industry at-large, or individual project participants if significant issues are observed.

B. Learning Collaborative

One facet of the DSRIP program is the development of the Learning Collaborative. The purpose of the Learning Collaborative is to promote and support a continuous environment of learning and sharing within the New Jersey healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in New Jersey.

The Learning Collaborative will be managed by the Department through both virtual and in-person collaboration that both builds relationships as well as facilitates program analysis and measurement. The Learning Collaborative will be designed to promote and/or perform the following:

- Sharing of DSRIP project development including data, challenges, and proposed solutions based on the hospitals' quarterly progress reports
- Collaborating based on shared ability and experience
- Identifying key project personnel
- Identification of best practices
- Provide updates on DSRIP program and outcomes
- Track and produce a "Frequently Asked Questions" document
- Encourage the principles of continuous quality improvement cycles

There will be multiple collaboratives developed based on the number and type of projects chosen by hospitals. For each collaborative, the Department will designate personnel to be responsible for guiding and facilitating the Learning Collaborative.

An online, web-based tool will be utilized in order to effectively manage the collection and the dissemination of information related to the DSRIP program and projects. A key component of the online tool will be a reporting feature that allows tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP

DRAFT - SUBJECT TO CHANGE

program. This tool will act as a repository with reporting capability for various audiences including that of the general public, the Department, CMS, and the healthcare industry.

The tool will deliver data in ways that can be 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

i. Operational Report

An operational report at the project level will be the primary report to manage and report DSRIP performance. The operational report will have the functionality to report on project-level data related to hospitals performing the same project. This may include such data elements as:

- Identification of participating hospitals
- Completion factor of hospitals, by Stage by hospital
- Dashboard of project-specific Stage 3 measure results
- Summary of applied interventions
- Summary of pilot models
- Summary of reported challenges
- Summary of reported successes
- Noted best practices

This report will be used to inform and direct the Learning Collaboratives. It will be used to ensure consistent analysis on key implementation activities across hospitals and act as a platform for discussion during monthly conference calls and quarterly in-person collaboration meetings. This report may be utilized by the hospital project personnel as a primary tool to aid routine collaboration among hospitals implementing the same project. This level of reporting may also show progress of the learning process itself by tracking the frequency of meetings by activity and participation in order to confirm that the learning collaborative activity is being fulfilled by the hospital.

It will be the responsibility of each project participant to ensure effective diffusion of learning amongst hospitals who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Study-Act (PDSA) cycles that have been implemented throughout the demonstration.

ii. Executive Level Report

An executive level report will have the functionality to report on high-level summary statistics related to the most recent quarter's DSRIP reports. This may include such data components as:

DRAFT - SUBJECT TO CHANGE

- Number of participating hospitals
- Number of approved/ rejected plans
- Count of plans by focus area and by project
- Completion factor of plans by Stage
- Dashboard of universal Stage 4 measure results

This report may be utilized by the public, CMS and the Department to track the overall progress of the DSRIP program.

iii. Consumer Level Report

A consumer level report will have the functionality to report on high-level geographic and project-specific data elements in order to understand which hospitals in their area are driving to improve quality and the area of focus for that hospital. The report may include:

- County-level map that indicates all New Jersey hospitals
- County-level map that indicates all participating hospitals and participating outpatient providers

This report may also have drill-down functionality to learn summary detail about the objective, methodology and expected results of each hospital.

C. DSRIP Program Evaluation

i. Evaluation Objectives and Research Questions

The Center for State Health Policy (CSHP) at Rutgers University will provide a mid-point assessment and a final, summative evaluation of the DSRIP program, answering research questions detailed in the "Special Terms and Conditions" (STCs) issued by CMS upon approval of the Comprehensive Waiver.

This evaluation has two components, both of which will utilize a mix of quantitative and qualitative methods:

1. A midpoint assessment which will provide independent quantitative analysis of DSRIP planning and implementation through December 2013, as well as timely qualitative research findings which will provide context for reports on hospitals' progress in planning and implementing selected DSRIP programs. The qualitative findings will contribute to understanding implementation issues which go beyond the quantitative analyses. In

DRAFT - SUBJECT TO CHANGE

addition, the qualitative analysis will inform and sharpen analytic plans for the summative evaluation.

2. The summative evaluation is designed to provide an independent analysis of key metrics to address how well the DSRIP Program achieves better care and better health for populations in the hospital catchment areas, as well as lower costs through improvement. Qualitative analysis, including key informant interviews and document review, will be conducted throughout planning and implementation of the DSRIP Program, to provide stakeholder perceptions of improvements in care and strengths and weaknesses of the program.

The mid-point assessment will be submitted by the end of June 2015. The final, summative evaluation will be completed by the end of March 2018.

The evaluation will use quantitative and qualitative research methodologies to test New Jersey's global hypothesis about the effectiveness of the DSRIP program.

"The DSRIP Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for populations and lower cost through improvement."

The following overall research questions (detailed in the STCs) guide the scope for the evaluation:

1) To what extent does the program achieve better care?
2) To what extent does the program achieve better health?
3) To what extent does the program lower costs?
4) To what extent did the program affect hospital finances?
5) To what extent did stakeholders report improvement in consumer care and population health?
6) How do key stakeholders perceive the strengths and weaknesses of the program?

Quantitative process and outcome measures along with inputs from qualitative analyses will be utilized to independently analyze data evaluating items 1-4. A qualitative approach will answer questions 5 and 6 based on stakeholder interviews, observations of program meetings, and review of relevant documents.

The mid-point and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

DRAFT - SUBJECT TO CHANGE

ii. Evaluation Hypotheses and Metrics

Hypotheses and sub-hypotheses will be tested relating to specific program interventions and population-focused health improvement initiatives.

Hypothesis 1: The adoption of projects in a specific focus area (e.g., cardiac care, asthma) will result in greater improvements in those outcomes for patients in hospitals adopting these interventions compared to hospitals which do not adopt these interventions.

After hospital projects are approved and finalized, this general hypothesis can be broken down into sub-hypotheses, tailored to specific projects; e.g.,

> Hypothesis 1a: Rates of 30-day hospital readmissions arising from heart failure, and associated costs will decrease in hospitals adopting cardiac care interventions during the DSRIP program.
>
> Hypothesis 1b: Rates of asthma admissions and ED visits will decrease for patients in hospitals adopting asthma management programs.

Hypothesis 2: During implementation of the DSRIP, population-based rates of potentially avoidable inpatient hospitalizations and treat-and-release emergency department visits (that reflect inadequate care) and associated costs will decrease among hospitals participating in the DSRIP.

Hypothesis 3: Hospitals which participate in the DSRIP program will improve racial/ethnic and gender disparities in avoidable hospital admissions, treat and release ED visits, and hospital readmissions.

Hypothesis 4: Hospitals which achieve their performance objectives and receive incentive payments under the DSRIP will experience no adverse impact on their finances.

Hypothesis 5: Stakeholders will report improvements in consumer care.

Hypothesis 6: Stakeholders will report improvements in population health.

Hypothesis 1 will examine the effectiveness of the individual projects by assessing hospital performance on the basis of selected metrics (See Table XI) which will be calculated for all hospitals. Calculation of project-specific metrics for all hospitals irrespective of the program chosen by them will facilitate evaluation of these programs by ensuring comparison groups. Table XII lists additional measures (relating to hypothesis 2) that reflect quality of care within the overall delivery system, such as rates of ambulatory care sensitive hospitalizations, and treatment costs at the hospital inpatient and ED care settings. These measures can be independently calculated from hospital discharge and/or claims based

DRAFT - SUBJECT TO CHANGE

data for comparison with hospital-reported data. In addition, these measures will be reported for all waiver populations, facilitating comparisons as appropriate.

Measures have been selected which can be independently calculated by the evaluator from hospital discharge and/or claims-based data and are thus available for all hospitals to facilitate comparison with hospital-reported data. Metrics that require medical charts and cannot be calculated from administrative data e.g., those related to screening for depression, are not included, since they cannot be independently calculated.

Measures are intended to reflect the effect of the intervention on the overall delivery system, e.g., readmissions or ambulatory care sensitive admissions. The measures were chosen to assess inpatient as well as ambulatory care received by patients, in contrast to much narrower inpatient process measures which are further removed from patient outcomes.

The list of metrics include those chosen to reflect the current policy changes related to hospital financing, such as rates of all-cause readmissions from initial hospitalizations of heart failure, AMI and pneumonia. The measures of potentially avoidable inpatient hospitalizations and primary care preventable/avoidable treat-and-release ED visits will be used across all populations covered by the Comprehensive Waiver Demonstration.

In addition, the evaluators will examine changes over the DSRIP years in up to ten (10) measures reported by hospitals or the State. For each metric, we will require the magnitude (N) of the population denominators used by each hospital as the basis for each measure in order to generate standard errors and compute statistically significant differences. The (N) refers to the actual number of the population denominator used for each measure that is required to calculate the standard errors for statistical comparisons. The ten measures chosen for evaluation reporting should not require adjustment for patient characteristics. A list of candidate measures might include:

- COPD Admission Rate
- CHF Admission Rate
- Controlling High Blood Pressure
- Breast Cancer Screening
- Cervical Cancer Screening
- Clamydia Screening in Women Age 21-24
- Diabetes Screening for people with schizophrenia or bipolar disorder who are prescribed with antipsychotic medications
- Measures relating to childhood immunization status; well-child visits; and access to primary care.

The final list may differ.

DRAFT - SUBJECT TO CHANGE

Table XI: Project-Specific Metrics

Stage III-Project	Metric	Data source
Asthma	Percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.*	UB; MC
	Adult Asthma Admission Rate	UB; MC
Behavioral Health	Follow-up After Hospitalization for Mental Illness (30 days post discharge)	MC
	Follow-up After Hospitalization for Mental Illness (7 days post discharge)	MC
Cardiac Care	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization**	UB; MC
	*30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization***	UB; MC
Chemical Addiction/ Substance Abuse	Engagement of alcohol and other drug treatment	MC
	Initiation of alcohol and other drug treatment	MC
Diabetes	Diabetes Short-Term Complications Admission Rate	UB; MC
HIV/AIDS	Percentage of HIV patients who had 2 or more CD4 T-cell counts performed during the measurement year	MC
Pneumonia	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	UB; MC

Notes:
Metrics adapted from the 'Catalogue of Project Specific Metrics' accompanying the DSRIP planning protocol
UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits
MC- Medicaid Claims & Encounter Data
Some metrics reflecting outpatient services can only be calculated with Medicaid claims data
*original metric included visits to urgent care office; which cannot be identified all-payer discharge data or Medicaid claims/encounter data

DRAFT - SUBJECT TO CHANGE

Table XII: Metrics for Overall Evaluation of the DSRIP Program

Stage IV Metrics	Description	Data Source
Mental Health Utilization	The number and percentage of patients receiving inpatient mental health services during the measurement year.	UB; MC
30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	UB; MC
30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	The percent of 30 day all-cause readmission rate for patients with AMI.	UB; MC
30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	The percent of 30 day all-cause readmission rate for patients with pneumonia.	UB; MC
30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	The percent of 30 day all-cause readmission rate for patients with COPD.	UB; MC
Hospital Acquired Potentially-Preventable Venous Thromboembolism	The number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	MC
Rate of potentially avoidable inpatient hospitalizations reflecting inadequate level of ambulatory care. Based on AHRQ methodology for calculating Prevention Quality Indicators.[51]		UB
Rate of Primary Care Preventable/Avoidable Treat and Release ED visits. Based on methodology by John Billings, New York University.[52]		UB
Total hospital inpatient , and treat-and-release Emergency Department costs stratified by patient age and race/ethnicity		UB
Hospital Total and Operating Margin		Hospital Financial Statements

Notes:
Metrics adapted from the Catalogue of Universal Metrics accompanying the DSRIP planning protocol
UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits
MC- Medicaid Claims & Encounter Data
Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

DRAFT - SUBJECT TO CHANGE

[51] Bindman AB, K Grumbach, D Osmond, M Komaromy, K Vranizan, N Lurie, J Billings, and A Stewart. "Preventable Hospitalizations and Access to Health Care." *Journal of the American Medical Association* 274, no. 4 (1995): 305–11.

[52] Billings J, N Parikh, and T Mijanovich. *Emergency Department Use: The New York Story*. New York: Commonwealth Fund, 2000.

The qualitative methods used to gather and analyze data to address Hypotheses 5 and 6 are detailed in section D.ii. below.

iii. Data Sources and Collection

The evaluation metrics (with the exception of hospital total and operating margin) can be consistently calculated across hospitals and for the state as a whole using all-payer, uniform billing (UB) NJ hospital discharge data, or NJ Medicaid paid claims and managed care encounter data. Those measures utilizing UB data can be calculated for all payers, while those using Medicaid paid claims/encounters can be calculated for Medicaid only. UB data will be used to identify trends in hospital utilization that may differ across payers.

UB data can be obtained approximately nine months after the end of each calendar year, although the data years can be aggregated to calculate measures using time periods which span successive years, e.g. federal fiscal years or other definitions used in endorsed specifications. CSHP has had an existing arrangement with the New Jersey Department of Health, Center for Health Statistics to merge multiple years of UB data to identify patient level utilization/ readmissions over time and provide the data without personal identifiers. This will provide the ability to track patients and utilization over time. We will work with the Department of Health to obtain approval to extend this arrangement for the DSRIP evaluation. CSHP is executing a Data Use Agreement with Medicaid which will provide paid claims and encounter data every six months during the period of the evaluation. Medicaid has advised us that all claims are subject to retroactive adjustment and have suggested that CSHP apply a lag period of nine months to allow for updates to the data for the most accurate measurement of utilization, costs and payments. Use of this approach would provide consistency and comparability with other parts of the evaluation.

The baseline period for the evaluation will be calendar years 2010-2012, and UB and Medicaid data for this period is expected to be available in late 2013. UB data can be updated annually, although the latest year for which annual hospital all-payer data will be available for the evaluation is 2016. Both the standard UB and the merged readmissions data which include calendar year 2016 should be available in the third quarter of 2017. Medicaid data will be available on a six-month basis throughout the evaluation through June 2017, although the final six months of data received in the third quarter of 2017 will not be updated with retroactive adjustments.

For the mid-point assessment, by the end of DY3, data on selected outcomes will be available from all-payer hospital data and Medicaid claims data.

DRAFT – SUBJECT TO CHANGE

- Rates of preventable hospitalizations (based on AHRQ Patient Quality Indicators) such as population based rates of asthma, COPD, diabetes and CHF admissions and rates of avoidable ED visits will be available for all payers for the baseline period (CY 2010 – 2012) and CY 2013. This will provide context about the overall NJ state population's use and access to hospital services, and allow comparison among subpopulations defined by demographic and payer groups. We will also calculate metrics detailed in the above tables for the baseline period and expect the necessary data to be available at that time.
- The metrics specified for evaluation will be calculated over the period from the start of the DSRIP project till the latest period for which data are available (expected to be CY 2013). Trends in metrics will be assessed by comparing their current values to those in the baseline period.

For the summative evaluation, 2016 data is expected in the third calendar quarter of 2017. Contingent upon timely receipt of Medicaid claims data from DHS and hospital discharge data from DOH, all analyses can be completed and a final summative report for the DSRIP can be delivered by March 31, 2018.

Rates and population denominators for the ten hospital or State reported measures selected for the evaluation should be provided to the evaluators at the time State reports are due.

Acute Care Hospital Financial Reports will be used to assess financial performance. All acute care hospitals submit these annually to the Department of Health by June 30 for the previous year. The reports are available after processing and auditing, approximately three months later.

iv. Evaluation Method and Design

The evaluation will identify the effects of the DSRIP program by measuring changes in the levels and trends of health care-related outcomes, and indicators of hospital financial performance (detailed in Tables XI and XII above) over time using comparison groups, wherever available. For this analysis, the various outcomes of interest will be analyzed at the hospital as well as patient level. The evaluation team will independently calculate all these evaluation-related measures for all hospitals using New Jersey all-payer discharge data or NJ Medicaid claims. The methods chosen will support measurement of the impact of the demonstration's interventions on the demonstration goals and sub-hypotheses, explain causal relationships, and explore the effect of other interventions in the state that may have interacted with this demonstration, such as the implementation of the Accountable Care Organizations and the effect of potential 2014 Medicaid expansion.

DRAFT - SUBJECT TO CHANGE

a. *Quantitative*

The evaluation will utilize a *difference-in-differences* estimation technique that examines specific performance measures in time periods *before* and *after* the implementation of the program/policy comparing DSRIP hospitals in specific programs and comparison hospitals not engaged in those interventions.

Such estimation strategy adjusts for temporal variations in outcomes, thereby distinguishing program impacts from secular trends. In order to generate comparison hospitals that are necessary to implement this approach, a selected number of project-specific metrics (see table XII) will be calculated for all hospitals using the NJ uniform billing data, or Medicaid claims, as described above. For example, trends in adult asthma admission rates will be calculated for all hospitals, comparing hospitals that selected asthma as one of the focus areas to those which did not. For both sets of hospitals, those with interventions for management of asthma and the comparison groups, we will use a baseline/ pre-intervention period of 3 years over 2010-2012.

For the measures used to evaluate all DSRIP hospitals, NJ-based comparison hospitals will be unavailable (unless some hospitals decline to participate in DSRIP). For those measures, segmented regression analysis/interrupted time series modeling will be used to allow inferences about DSRIP impact. Interrupted time series modeling will also be used to identify the effect of DSRIP on financial performance of hospitals. We will use operating margin, total margin and other indicators of financial performance that will be available to assess hospital finances. Our estimation procedures will be conducted using standard inferential statistical techniques employing STATA 12.1 or SAS 9.2 software.

The evaluation questions will involve calculation and examination of performance metrics for individual hospitals – comprising intervention and comparison groups. All these rates will be stratified by race/ethnicity and age. Because of the diversity of the New Jersey population, we expect to find differences in the effect of the DSRIP program among demographic groups and we will document these differences.

We also will replicate the statistical analysis for these subpopulations of hospital patients to further identify the effects of the intervention within patient groups classified by these demographic characteristics to the extent that sample sizes permit. Finally, we will examine the metrics for all payers combined and also, where supported by the data, separately for Medicaid patients. Hospital-level trends will also be compared to benchmark statewide trends. For population-based measures (e.g., adult asthma discharge rate), we will define market catchment areas for each hospitals defined as the

DRAFT - SUBJECT TO CHANGE

smallest number of zip codes accounting for 80% of the respective hospital's total inpatient admissions. Age-sex adjustment, whenever appropriate, will be applied in calculating these measures. We will also review hospital-reported data relating to our selected evaluation metrics for accuracy and consistency in measurement across hospitals.

b. *Qualitative*

To address research questions 5 and 6, assessing stakeholder perceptions, the evaluation team will develop interview protocols and web surveys to gather views of stakeholder perceptions about DSRIP program effectiveness in improving access, quality of care, and population health outcomes.

Qualitative data will be collected in two phases. Information from phase 1 will be utilized to enhance and expand quantitative findings for the mid-point assessment, and information from phase 2 will be added to phase 1 for the summative evaluation:

Phase 1) Stakeholder feedback regarding the process of planning and implementing the DSRIP, to be collected from September 2014 to February 2015; and

Phase 2) Stakeholder feedback about the successes and challenges of the DSRIP program, to be collected January 2017 to April 2017.

Both phases will utilize key informant interviews and a web survey, as well as the analysis of information from hospital projects, such as program materials, community outreach materials, and presentations. The evaluation team will also review planning and implementation documents and reports from participating hospitals to provide background for the stakeholder feedback. Our reports will draw on the monitoring and award information as we fully describe DSRIP activities and outcomes. Interview and survey protocols will be approved by the Rutgers University Institutional Review Board, and interviewers will be trained to ensure privacy and confidentiality.

During phase 1, the evaluation team will gather information regarding the questions detailed below, as well as others suggested by DSRIP stakeholders.

- What positive impacts are expected from the DSRIP project? Which patient and/or community groups are expected to benefit?
- Are any spillover effects expected which could affect other hospital programs or hospital finances positively or negatively?
- What difficulties were encountered in developing a DSRIP project, e.g., obtaining resources, engaging community partners, sharing clinical data, etc.?

DRAFT - SUBJECT TO CHANGE

- What difficulties were encountered in applying for approval of a DSRIP project? Can the process be improved?
- What additional information would have been helpful in applying for the DSRIP program?
- What difficulties were encountered in initial implementation of the DSRIP project?
- What difficulties were encountered in collecting accurate data about the project?
- What changes in policy or practice external to the DSRIP have affected implementation of the DSRIP or made it difficult to gather accurate information?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What improvements in health care were made as a result of the DSRIP projects?
- What new clinical partnerships were developed?
- How were real time data used to support the efforts of hospitals to refine their programs?
- How did the learning collaborative support change?
- What other rapid-cycle improvement tools were used and how effective were they in supporting quality improvement? Was there adequate support for hospitals for these activities? What could make the rapid-cycle tools (e.g. learning collaborative, dashboards, real time data exchanges, etc.) more effective?

Key informant interviews will be conducted with officials from the Department of Health and the Department of Human Services, as well as executives who served on the DSRIP steering committee from the New Jersey Hospital Association, the Hospital Alliance, and the Council of Teaching Hospitals. If any acute-care hospitals do not participate in the DSRIP, we will seek key informant interviews with representatives of those hospitals. Interviews will also be conducted with representatives from hospitals' community partners to obtain viewpoints about expected benefits and unanticipated consequences for patients and families.

Interviewers will use a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and

DRAFT - SUBJECT TO CHANGE

probes to elicit more in-depth responses to the primary questions. Data from key informant interviews will be transcribed and de-identified, then independently coded by two researchers to identify themes and patterns in the data. Ongoing analysis of completed interviews will inform subsequent interviews.

A web survey will be developed, informed by a review of the approved DSRIP project plans and information from the key informant interviews. The survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals. Hospitals will provide valid contact information. In addition to the topics noted, questions may include asking about previous activities relating to the hospital's focus area, approaches to enrolling patients, responses from different groups within the community, unexpected successes, and recommendations for other hospitals. Advance communication about the survey will be sent in collaboration with the Department of Health and the hospital associations. Two follow-ups will be sent in addition to the original distribution of the surveys.

Data from the web survey will be analyzed using statistical software for closed-ended questions and items which can be coded into simple categories. If open-ended questions requiring complex responses are used, these responses will be analyzed along with the key informant data.

A report summarizing findings from phase 1 will be completed by June 2015, which will be incorporated in the mid-point assessment.

For the summative evaluation during phase 2, the primary objectives will be to gather information regarding the following questions, along with others which will emerge during the implementation of the DSRIP:

- What improvements in health care were made as a result of the DSRIP projects?
- Which community/patient groups benefitted most?
- What new clinical partnerships were developed?
- What new community partnerships were developed?
- What difficulties were encountered during the DSRIP implementation?
- How were difficulties addressed? Which strategies were most successful?

DRAFT - SUBJECT TO CHANGE

- How did community members react to the DSRIP project? Were there different reactions from different parts of the community?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What help was provided by the Learning Collaborative? What could have made the Learning Collaborative more successful?
- Were there unanticipated consequences in hospital operations, other programs, or financial status?

Key informant interviews will be conducted with community advocates, officials from the Department of Health and the Department of Human Services, staff of the Learning Collaborative, and members of the DSRIP steering committee. The information from these interviews will inform the development of the web survey.

A web survey will be developed to gather information about implementation of DSRIP over time, experiences with the Learning Collaborative, successes achieved by DSRIP projects, and suggestions for improvement. As in phase 1, the survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals.

Data from key information interviews and web surveys in phase 2 will be analyzed in accordance with the methods in phase 1, and the summative review will be completed by August 30, 2017.

v. Evaluation Reports and CMS Opportunity to Comment

On or before the date by which CMS must make its final decision on Hospital DSRIP Plans, the Department will submit the detailed plans and protocols for the mid-point and summative evaluations for review and comment. CMS will return comments to the Department within 60 days of receipt, and the Department will submit its revised plans and protocols to CMS within 60 days of its receipt of CMS comments.

For the mid-point and summative evaluations, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the Department or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the Department. Draft versions of

DRAFT - SUBJECT TO CHANGE

reports related to the midpoint and summative evaluations will not be routinely released, except as required by state and Federal law.

Data and findings resulting from all stages of the evaluation will be publicly shared as part of the Department's commitment to feedback and continuous improvement. Key pathways for dissemination and use of the evaluation findings beyond the required reporting to CMS include:

- Posting to publicly available websites
- Making copies of the mid-point and summative evaluations available to the Quality & Measures Committee

Prior to July 1, 2019 (two years after the end of the demonstration), or 12 months from the date that the final reports for these evaluations are provided to CMS (if later), CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the evaluator or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline to review, some or all, of these notifications and reports.

New Jersey agrees that, when draft and final midpoint and summative evaluation reports are due, CMS may issue deferrals for an amount equal to 5 percent of one quarter of the total annual amount available for DSRIP (which is equal to $1,041,250 in FFP) for any such reports that are not provided timely to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

DRAFT - SUBJECT TO CHANGE

DSRIP Evaluation Activities	2013		2014				2015				2016				2017				2018	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Design protocols/IRB submission	■																			
Document review		■		■		■		■		■		■		■	■					
Design web survey		■									■									
Administer web survey			■	■								■	■							
Analyze web survey data					■									■						
Submit request for special UB linked data		■																		
Receive UB annual hospital discharge data					■				■				■				■			
Execute DUA for Medicaid data	■																			
Receive Medicaid claims data		■		■		■		■		■		■		■		■				
Receive linked hospital UB data					■				■				■							
Data preparation			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		
Data analysis				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
Conduct key informant interviews			■	■	■	■	■		■	■	■	■	■	■	■					
Analyze interview data							■								■					
Prepare Mid-Point Assessment Report								■												
Prepare Final Evaluation Report																			■	

DRAFT - SUBJECT TO CHANGE