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Evaluation of the New Jersey DSRIP Program: Findings from the Third Round of Stakeholder Interviews

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Executive Summary

Background

The Delivery System Reform Incentive Payment (DSRIP) Program was approved as part of the New Jersey Medicaid Comprehensive Waiver Demonstration in October 2012. It was re-authorized for a 3 year extension period under the Demonstration renewal for a total of eight demonstration years ending in June 2020. The hospital-based DSRIP program uses resources transitioned from the previously existing Hospital Relief Subsidy Fund to establish a pay-for-performance and pay-for-reporting system to achieve specific health improvement goals for the state's low income population.

Over the course of this program, participating hospitals received payments for developing, implementing, and monitoring specific disease management projects; for reporting/verifying sets of metrics: specific quality metrics related to their adopted projects and also universal population focused metrics; for improving performance assessed on the basis of the project-specific metrics; and for improving or maintaining performance on a core set of metrics relating to inpatient care through funding available from a Universal Performance Pool.

The Rutgers Center for State Health Policy (CSHP) was engaged to evaluate the effectiveness of New Jersey's DSRIP program in achieving its goals. We formulated specific testable hypotheses to examine the following six research questions from the DSRIP Planning Protocol (detailed in the Waiver Special Terms and Conditions document) that determine the scope of the evaluation:

1. To what extent does the DSRIP program achieve better care?
2. To what extent does the DSRIP program achieve better health?
3. To what extent does the DSRIP program lower costs?
4. To what extent did the DSRIP 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 DSRIP program?

This document is the third in a series of reports, and presents a qualitative assessment during the extension period, demonstration years (DY) 6 to 8, of the impact of DSRIP program activities through stakeholder perceptions relating to implementation and potential of future DSRIP-like programs. Complete findings from the previous two rounds can be found in the DSRIP Midpoint Evaluation (Chakravarty et al. 2015) and the DSRIP Summative Evaluation (Chakravarty et al. 2018), respectively.

Key Informant Interviews

This report discusses a third round of semi-structured telephone interviews with key informants, including hospital staff members, members of various DSRIP Programs, and officials from the New Jersey Department of Health, who were familiar with the program. We included safety net providers as well as those serving more income-secure populations. There was some overlap in interviewees across the previous two rounds. With each interview session consisting of 1 – 3 key informants, we conducted 13 interviews (24 subjects total) from July – September 2020.

Summary of Findings

As previously reported, participants continued to be enthusiastic about chronic disease management interventions and, in some respects, with the Learning Collaboratives, where they were able to discuss their interventions and build relationships with other hospitals. They generally remained unsatisfied with reporting requirements, particularly with respect to the universal metrics, and also in some cases with the project-specific metrics when they felt that the metric did not fairly represent outcomes. With the universal metrics (reported for all attributed patients), many participants found them to be a significant burden and also questioned the purpose or value of reporting those metrics. By the second round of interviews, most reported positive effects on health outcomes from the chronic disease interventions but generally could not say how overall costs were affected, and this continued in the third round. The value of project partners was recognized, but resource constraints continued to be a barrier to forming effective partnerships with outpatient providers. Finally, participants offered suggestions for future rounds of DSRIP-like programs, including paring down required metrics, risk-adjusting measures for population factors, involving hospitals and outpatient partners in program design, and devoting more resources to outpatient partners and information technology.

Discussion

This report examines information based on stakeholder interviews to examine implementation and identify the effects of the NJ DSRIP program using qualitative research techniques during the DSRIP transition and implementation years, from October 2012 through June 2020.

The strength of the DSRIP program, according to stakeholders, was the opportunity it provided to redesign care of chronic conditions for patients. On average, hospitals agreed that the DSRIP program improved chronic disease management processes at their hospital, and fostered community partnerships that have a positive impact on social determinants of health. While the program sometimes strained hospital resources (especially for safety net hospitals), there were reports of positive outcomes in terms of reduced emergency room visits and hospital readmissions. The weaknesses of the DSRIP program according to stakeholders had primarily to do with the reporting requirements of the program. These required a large investment of time and resources which were perceived as a distraction from patient care. Questions remained about the value and validity of the metrics utilized to capture the efforts and progress made by hospitals in caring for their low-income patients.

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Background

The New Jersey Delivery System Reform Incentive Payment (DSRIP) program was a federal initiative negotiated between the state and the Centers for Medicare and Medicaid Services under Section 1115 waiver authority. The hospital-based DSRIP program uses resources transitioned from the previously existing Hospital Relief Subsidy Fund to establish a pay-for-performance and pay-for-reporting system to achieve specific health improvement goals for states' Medicaid, Children's Health Insurance Program (CHIP), and charity care beneficiaries. New Jersey's DSRIP Program was approved as part of the New Jersey Medicaid Comprehensive Waiver Demonstration in October 2012 and re-authorized for a 3 year extension period under the Demonstration renewal[1] for a total of eight demonstration years (DYs)[2] ending in June 2020.

Under the New Jersey DSRIP Program, hospitals developed and implemented community-based chronic disease management programs addressing one of eight conditions identified by the State as priority areas for quality and cost improvement efforts: asthma, behavioral health, cardiac care, chemical addiction/substance abuse, diabetes, HIV/AIDS, obesity, and pneumonia. Projects had to be evidence-based, include an outpatient focus, and specify relevant and validated outcome metrics for performance assessment.[3] Of the 63 eligible NJ hospitals, 55 applied to participate in DSRIP and 46 hospitals remained in the program through the end of DY8.[4]

[1] CMS (Centers for Medicare & Medicaid Services). 2017. New Jersey FamilyCare Comprehensive Demonstration (Project No. 11-W-00279/2). Baltimore: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-ca.pdf.

[2] The first DY of DSRIP was shortened, running from October 2012, when the Comprehensive Waiver governing the DSRIP program was approved, to June 2013.

[3] New Jersey Department of Health. Delivery System Reform Incentive Payment (DSRIP) Program Planning Protocol. August 9, 2013. https://dsrip.nj.gov/Documents/NJ%20DSRIP%20PLANNING%20PROTOCOL_v1_08-09-2013.pdf.

[4] Some hospitals withdrew from DSRIP during the implementation period so that by the end of DY5, 49 hospitals remained in the program. Another 3 hospitals withdrew in DY6.

Table 1 shows some characteristics of hospitals that participated in the DSRIP program as well as those that opted not to participate and those who participated initially, but dropped out at some point during the program. As shown in the table, the nonparticipants had the lowest average bed size, and nonparticipants and dropouts had lower average bed sizes and lower average charity care reimbursements compared with participating hospitals.

Of the participating hospitals, 57% were former recipients of the Hospital Relief Subsidy Fund (HRSF), meant to compensate existing Disproportionate Share hospitals for treatment of particular high-risk patients, and 33% were members of the Hospital Alliance (HA) of New Jersey, a group of safety net hospitals serving populations with multiple vulnerabilities. About 30% (n=19) of the DSRIP participating hospitals were neither former HRSF recipients nor HA members. All but one HA member were former HRSF recipients (14 out of 15, or 93%); 54% of former HRSF recipients were HA members (14 out of 26).

The three types of DSRIP participating hospitals (HRSF recipient, HA member, and other/neither these) had similar average bed sizes, but those hospitals that were neither former HRSF recipients or HA members had lower average earnings from DSRIP as well as lower average charity care reimbursements. HA members stood out with respect to getting much more compensation from charity care relative to DSRIP whether measured as an average total dollar amount or an average per bed count. The relative reimbursement amounts of the two programs (per hospital bed) were similar for former HRSF recipients and the hospitals that were neither HRSF recipients or HA members.

Table 1: Characteristics of DSRIP Participants, Nonparticipants, and Dropouts

	Number of Hospitals*	% Received HRSF Funding (2011)*	% Members of Safety Net Alliance**	DY7 Interim Final DSRIP Pmt (2019)*	Average Charity Care (CC) Reimbursement, 2019*	DY7 as % of CC***	Average Bed Size****	Average DY7 $ per bed***	Average CC $ per bed***	DY7 per bed as % of CC per bed***
DSRIP Participants	46	57%	33%	$3,621,739	$5,539,291	65%	357	$10,856	$17,255	63%
HRSF recipient	*26*	*100%*	*54%*	*$5,888,434*	*$8,702,362*	*68%*	*359*	*$17,589*	*$26,085*	*67%*
HA member†	*15*	*93%*	*100%*	*$6,861,888*	*$14,652,701*	*47%*	*385*	*$17,630*	*$44,913*	*39%*
Other	*19*	*0%*	*0%*	*$647,193*	*$889,416*	*73%*	*362*	*$1,879*	*$2,855*	*66%*
Dropped Out	9	0%	0%	n/a	$209,589	n/a	204	$0	$929	n/a
Nonparticipants	8	0%	0%	n/a	$255,883	n/a	181	$0	$1,579	n/a
All Hospitals	**63**	**41%**	**24%**		**$4,106,996**		**313**		**$13,132**	

Sources: *NJDOH, **https://www.hospitalalliance.org/, *** author's calculations from named sources, ****American Hospital Directory tabulation of CMS staffed beds with one NJDOH substitute where AHD was missing, †14 of 15 HA members were also HRSF recipients, so the 3 subgroups add to more than 46.

Table 2 shows the focus areas and specific projects that hospitals selected. The majority of hospitals selected programs in cardiac and diabetes care, with none choosing an HIV/AIDS project, and only one hospital each with projects in the pneumonia and obesity focus areas.

Table 2: Hospital Chronic Disease Focus Areas and Specific Projects

Focus Area	Percent of Hospitals	Project Name	Number of Hospitals	Percent of Hospitals
Asthma	9%	Hospital-Based Educators Teach Optimal Asthma Care	2	4%
		Pediatric Asthma Case Management and Home Evaluations	2	4%
Behavioral Health	9%	Electronic Self-Assessment Decision Support Tool	2	4%
		Integrated Health Home for the Seriously Mentally Ill (SMI)	2	4%
Cardiac Care	46%	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	11	24%
		Extensive Patient CHF-Focused Multi-Therapeutic Model	4	9%
		The Congestive Heart Failure Transition Program (CHF-TP)	6	13%
Chemical Addiction and Substance Abuse	11%	Hospital-Wide Screening for Substance Use Disorder	5	11%

Diabetes	22%	Diabetes Group Visits for Patients and Community Education	6	13%
		Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	4	9%
Obesity	2%	After School Obesity Program	1	2%
Pneumonia	2%	Patients Receive Recommended Care for Community-Acquired Pneumonia	1	2%
Total	*100%*		*46*	*100%*

Source: https://dsrip.nj.gov/Documents/NJ DSRIP DY6-DY8 Planning Protocol_CMS approved_02082019.pdf

After initial project approval, a pay-for-reporting (P4R) and pay-for-performance (P4P) arrangement incentivized hospitals' progress through four cumulative stages. In the first five DYs, these stages were infrastructure development (Stage 1), chronic medical condition redesign and management (Stage 2), quality improvements (Stage 3), and population-focused improvements (Stage 4). During infrastructure development (Stage 1), hospitals carried out activities that developed and refined the administrative, technological, and human resources foundation for their projects. The chronic medical condition redesign and management stage (Stage 2) was when hospitals tested their care models in a pilot and made any changes necessary to bring the project to scale. Ongoing monitoring of programs and feedback for hospital administration, participating providers, and the DSRIP community were also part of all hospitals' Stage 2 activities. In Stages 3 and 4, hospitals had to report on a menu of project-specific and population health-related quality metrics calculated for an annual performance period. Stage 3 project-specific metrics were tied to a hospitals' chosen project and therefore, differed by hospital. Hospitals had to select at least two and up to four Stage 3 metrics on which to base their performance payments.[5] Achieving these payments required closing the gap between baseline and an established improvement target goal. All hospitals had to report the same Stage 4 "universal" population health metrics and these remained P4R through DY5. In the DSRIP extension period, the original Stage 1 and Stage 2 activities were phased out, and universal reporting on a set of ten "System Transformation" measures was added as the new Stage 1 by

[5] Sometimes, a selected Stage 3 P4P-eligible metric would not qualify for P4P for a particular hospital if their baseline performance did not meet CMS required threshold for improvement. In that case, hospitals would be instructed to choose a substitution metric.

DY7. Stage 3 became Stage 2, and Stage 4 became Stage 3 with an added P4P component. The performance calculation mechanics were also modified.

CMS viewed DSRIP as an opportunity to increase hospitals' involvement in the continuum of patient care and therefore, the mechanics of DSRIP were designed to strengthen partnerships between existing inpatient and outpatient providers and incent the development of new partnerships. Procuring project partners was part of hospitals' required activities. Project partners were defined in DSRIP as any entity helping a hospital achieve the aims of their DSRIP program – schools, YMCAs, and FQHCs were all examples of project partners. Quality metric reporting required an expanded role for some project partners having clinical involvement with DSRIP patients. A majority of quality metrics were calculable solely from administrative claims data (MMIS data) and so was prepared by the State on behalf of the hospitals (and subject to hospitals' verification). But any metric requiring data from paper or electronic medical records had to be prepared and reported by the hospitals in coordination with data-reporting outpatient partners as necessary. Partners like a Medicaid-enrolled clinic, facility, or physician practice group willing to comply with reporting outpatient data would qualify as such a "reporting" partner. A hospital-based clinic could fulfill the role of a reporting partner, but CMS encouraged hospitals to formalize or establish new relationships with other outpatient providers.

Quality metrics were calculated for a hospital's specific attributed population. A utilization-based model, developed by the State with input from the hospital industry and approved by CMS, used administrative claims data to link hospitals with a population of Medicaid, CHIP, and charity care patients. The final attribution model was based on two years of utilization for "evaluation and management" visits at hospital-based clinics, emergency departments, and any other reporting partners participating with a hospital on its DSRIP program. Because patients had to be linked to a single hospital for monitoring performance, reporting partners could only formally align with one hospital for DSRIP purposes, although in practice, they could continue to work with patients from multiple hospitals, coordinating treatment and providing services. The State calculated two attribution rosters for hospitals: a prospective roster provided to hospitals at the start of the performance period to preliminarily identify patients whose outcomes the hospital may be responsible for, and a retrospective roster computed at the end of the performance period using patients' most up-to-date experience and claims history. All of a hospital's metrics were calculated for the final, retrospective attributed population.

Given its accountability focus, documentation and reporting were major features of DSRIP. Besides the initial application and the quality metric reporting described above, hospitals also had to submit annual reapplications and quarterly progress reports. Acceptable progress reports used a State-approved template to provide details describing all required and elective quarterly

DSRIP activities such as projected deadlines, narratives of activity developments and outcomes, and descriptions of stakeholder engagement activities, to name a few. Some progress reports required additional components, for example, comparing original and current budgets and ROI analyses. Minimum submission requirements were established for all elements of progress reports and, if not met, hospitals received "write-backs" from the State. In DY7, a Measure Verification Template was introduced to improve the State's and CMS's ability to review data accuracy in hospitals' reporting workbooks. Training and guidance documents were provided by the State to assist hospitals in complying with DSRIP's many reporting guidelines. During the later years of the program, performance review and technical assistance letters, based on quality metric data hospitals had been submitting over the years and measures calculated on their behalf by the State, were shared with DSRIP hospitals. These personalized letters were intended to help hospitals interpret their performance data in the DSRIP online dashboard, gave commentary on trends in their performance, and provided an overview of risks and opportunities for earning payments across stages.

Another requirement of DSRIP hospitals was participation in the Learning Collaborative (LC). The LC was a venue for learning and sharing among all DSRIP-participating hospitals and further, among all hospitals implementing projects within a chronic disease area. At LC meetings, hospitals could share experiences, solutions to challenges, and success stories. Training on the use of rapid-cycle improvement tools to help hospitals meet their DRSIP project goals was provided. The State could identify best practices and answer or investigate any outstanding questions from hospitals. Learning Collaboratives were held regularly through the demonstration period. Attendance by two representatives per hospital on all LC calls and in-person meetings was required, and after each LC, hospitals had to complete a survey as part of their required reporting.

Evaluation Overview

The Rutgers Center for State Health Policy (CSHP) was engaged to evaluate the effectiveness of New Jersey's DSRIP program in achieving its goals. We formulated specific testable hypotheses to examine the following six research questions from the DSRIP Planning Protocol (detailed in the Waiver Special Terms and Conditions document) that determine the scope of the evaluation:

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3. To what extent does the DSRIP program lower costs?
4. To what extent did the DSRIP 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 DSRIP program?

The hypotheses were tested utilizing a mix of quantitative and qualitative methods. Findings for the first five years of the program authorized under the original Comprehensive Waiver Demonstration were previously presented in two reports: a midpoint evaluation completed in September 2015 (Chakravarty et al. 2015), focusing on the DSRIP planning and early implementation period (through the first half of DY3), and a summative evaluation (Chakravarty et al. 2018) covering the full implementation period under the base Demonstration (through the end of DY5).

This third stakeholder report presents qualitative assessments of the impact of DSRIP program activities through the last demonstration year in the extension period (DY8) captured through stakeholder perceptions relating to implementation activities, DSRIP impact, and potential of future DSRIP-like programs. Quantitative findings will be presented in a subsequent report.

Evaluation Findings Based on Key Informant Interviews

Overview

Key informant interviews are part of the qualitative evaluation of the DSRIP program. They are designed to 1) directly address research questions specified in the Waiver Special Terms and Conditions document related to stakeholder perceptions of improvements in consumer care and population health as well as stakeholder perceptions of strengths and weaknesses of the program, and 2) inform the evaluation and help interpret findings by querying stakeholders for potential program and implementation issues, some of which may not have been anticipated at the time of the initial research design. This report focuses on a third round of key informant interviews conducted from July through September 2020.

Methods

Subject Recruitment

The research protocol was approved by the Institutional Review Board at Rutgers. This report focuses on the third round of telephone interviews conducted from July through September of 2020, and consisting of 13 interviews with 24 key informants. Interview sessions ranged from 1 to 3 participants and included hospital staff members, members of various DSRIP Program committees, and officials from the New Jersey Department of Health. Some participants have been engaged in DSRIP activities since DY1; others had more recent involvement beginning in DY7. We included safety net providers as well as those serving more income-secure populations.

There was some overlap in interviewees across the three rounds: five of the hospitals had been included in past interviews (participating staff was sometimes different), and four interviewees had participated in past rounds.

DSRIP participating hospitals were selected based on geography and payer mix to facilitate a robust representation. Our strategy in all 3 rounds was to get a mix of hospitals from the North, Central, and Southern regions of the state, and a mix of safety net and non-safety net hospitals. We also recruited outpatient partners and other stakeholders such as provider associations and state officials. Where relevant, we recruited withdrawn hospital (rounds 1 and 3) and nonparticipating hospitals (round 1 only). Appendix D shows details on organizations recruited and interviewed by region and interviewee type. For efficiency in recruitment management, we conducted the recruitment in phases from June through August 2020. (Interviews were conducted from July through September 2020). Generally, potential key informant interviewees were emailed an invitation package, including an invitation letter, oral consent form, interview questions, and the Midpoint and Summative Reports. Two to three subsequent emails were sent to non-responders and afterwards, we telephoned the invited key informant interviewees with a reminder of the invitation. To facilitate recruitment after a second wave of invitations, we employed the assistance of the NJ Department of Health officials managing the DSRIP program who reminded the participating hospitals of our evaluation project and request for interviews. After identifying additional hospitals for enrollment, we conducted an additional round of recruitment.

Question Development

The interview questions (available in Appendices A, B and C for the 3 interview rounds) were constructed so as to address the research questions detailed in DSRIP Planning Protocol based on the Waiver Special Terms and Conditions. Question formulation was informed by knowledge gained by CSHP researchers through participation in various meetings, conference calls, and information published or distributed regarding the DSRIP program. An initial draft of questions was piloted in the summer of 2014 in three informal telephone interviews conducted with stakeholders knowledgeable about program operations. These pilots facilitated refinements to the initial draft of the questions for the first round of interviews. For the questions used in the third round of interviews, researchers considered findings from the midpoint and summative evaluation reports (Chakravarty et al. 2015 and Chakravarty et al. 2018) as well as information gleaned from later meetings, conference calls, and information distributed regarding the DSRIP program.

Questioning Strategy

Interviewers used a semi-structured list of basic questions with detailed potential follow-up questions noted in advance and also created new follow-up questions at the time of the interview if appropriate. Semi-structured interviews were conducted to understand and illuminate perspectives of service administrators and providers in implementing DSRIP activities. We used qualitative methods to build new understandings of the mechanisms that facilitate success of a statewide initiative and aimed to capture the experiences of stakeholders following implementation of DSRIP. See Appendices A-C for the specific questions.

Documentation and Analysis

At least two CSHP researchers participated in all interviews and created a preliminary summary of each session. The summaries were reviewed and edited by research team members to ensure agreement across the team on the content of each interview. The interviews were audio-recorded and transcribed for additional review and analysis. Consistent with previous rounds, there were no basic disagreements about themes, though there were a few minor differences in emphasis.

Findings

In the following, we discuss findings related to topics covered in the third round of interviews, including how views on these topics shifted over time based on our previous rounds of interviews.

Topic	Round 1	Round 2	Round 3
Chronic disease programs & population health	Hospitals were enthusiastic about chronic disease management and population health improvement, though uncertain about which specific interventions are best.	Hospitals remain enthusiastic about chronic disease management and population health improvement. Most felt that their DSRIP initiatives underscored the importance of connecting with the community outside the hospital and helped them to do so. However, lack of resources for outpatient partners may have limited these connections.	Hospitals remain enthusiastic about their DSRIP initiatives and most hope to continue them beyond DSRIP for the sake of the health of their community members, but not all have identified sufficient resources to do so. Relationships with project partners were beneficial, but barriers to effective clinical partnerships were still mentioned.

Consistent with project findings previously reported, recent third round interviews revealed that most hospitals had some ongoing chronic disease management and/or population health initiatives with DSRIP and independently of DSRIP. Several interviewees noted the importance of connecting with community resources outside the hospital to effectively manage chronic diseases and felt that DSRIP helped them to do this. However, the program design did not allocate new resources for outpatient partners - the funding pool was based on the historical Hospital Relief Subsidy Fund, which had compensated hospitals based on the numbers of uninsured and Medicaid patients they served (Kitchenman 2014; NJDOH 2013). While hospitals could choose to compensate partners (and some did, although anecdotally at least, such compensation was limited), the funds would have to come out of their resources, which many hospitals, particularly the safety-net hospitals, felt were quite limited already. Clinical and community partners remained an important support for the various programs. Aside from supporting the program in fulfilling DSRIP reporting requirements, partners were essential in facilitating security and trust between patients and programs. Select DSRIP programs built on pre-existing relationships and other programs engaged with new partners. However, participants explained that some of these informal relationships were complicated by expectations. Financial equity and human resources proved to be sources of contention as partners sought compensation for their efforts, as participants explained:

> *"But I think also in the year six through eight, the issues with partners where the partners started really demanding to get some of the DSRIP money to be able to continue to partner with you, with us occurred in several [outpatient] partners and they wanted some of the money, some of the take as they say, because they're partnering with us and that they wanted some of the money for that. So that became actually very, I wasn't contentious, but some of them got very, very vocal and was refusing to give us data and that kind of thing because they felt like we were getting extra money, we didn't understand the funding process with this."*

> *"We actually had [a partner] that demanded that we have our specialists ... see their patients. And we can't mandate a private physician to take on patients, so they refused to partner with us."*

> *"And partnering with some of the outside community providers that are not in our network has proven difficult. They're not incentivized to participate, so they're not really jumping at the opportunity to give us their data or in a timely fashion."*

Competition and program longevity/duration may have also affected the development of partnerships, as shown in the quotes below.

"And although we did eventually get some loose partnership with them, we were never able to get any true formal and really deeply rooted partnership with them. And partly, I think there was concern on the outpatient behavioral health center side about, for lack of a better way of saying it, of stealing patients from them."

"I really do believe that there were some barriers or problems that really came up. It seemed like a lot of hospitals kind of lost their mojo and that they became more status quo because related to the uncertainty of the programs, are they going to be funded? Are they not going to be funded? What is going on? What does the new one look like? Should we just continue kind of doing what we're doing because we don't know what the focus is?"

Topic	Round 1	Round 2	Round 3
DSRIP program outcomes	Participants thought it too early to determine definite outcomes from the program, either positively or negatively.	Most participants seemed to feel that there were positive care outcomes resulting from the chronic disease programs. Participants were not sure if there were significant cost savings to the delivery system as a result of these programs, and also seemed unsure of the value of the universal metrics.	Participants consistently reported decreases in ED/inpatient utilization and increases in patient adherence to primary care, but none had documented specific savings. More value was observed in this round from the universal metrics, though many still questioned some of these (and most felt there were too many).

Round 3 interview participants uniformly reported achieving positive outcomes as a direct result of DSRIP program activities. Whether DSRIP support enhanced existing infrastructure or provided the impetus to address community needs, DSRIP programs were essential to these changes. Aligned with previous reports, the perception of program outcomes may be indicative of the maturity of the project, the change in patient behaviors, and adaptation by the hospital. At the time of the third round of interviews, most chronic disease interventions had been operating for several years, and while interview participants could only provide anecdotal accounts of positive outcomes, they were proud of the achievements derived from their chronic disease program, as DSRIP directors and team members explained:

"I think just getting patients into appointments much more quickly than the average was a huge improvement for the patient population that we were seeing...So a lot of their chronic health conditions were able to be a little better managed and stayed abreast of....in between appointments [workers] were checking in on a very regular basis with

those patients to make sure that they were adhering to medications, that they were able to get medication, kind of observing them for decompensations both medically and behaviorally."

"So from the beginning, as soon as the patient is coming on the floors, we're getting notified, we meet with the patient as quickly as possible and start the whole process of either doing education or working on trying to get them a discharge plan, whereas none of that was happening before…We're linking them with resources, education, and often educating medical personnel along the way. I think we're looking at improving overall health by doing all of those things."

"the patients we started seeing at the clinic, their acuity levels fell way, way, way, down, … they were getting the care that they needed… cannot emphasize enough, the home visits that we did, that made it so much more accessible and convenient … able to assess the home, assess what resources they have at home, meaning their family … their financial resource. Are they on medication, are they taking their medications? Is there even food in the home? Is there a refrigerator in the home … the knowledge that we came back with after doing these home visits was just unbelievable … [some very bad outcomes] we actually avoided, with patients who didn't show up for their visits ... we followed up, went to the home visit … we had to act immediately, got a lot of people involved to do treatment, specialists to do care."

"identified that that was a high risk for us, as the patients … coming in, not being treated appropriately. So we took that incentive and we really went out into the community … we went to churches, we went to health fairs, we went to the schools, educating them on [condition] … so they can prevent a readmission to the emergency room or being admitted. So we partnered with [organization], and we provided supplies, education for them. Also we partnered with [organization], where a group went in and they [made home improvements]."

Interview participants cited the DSRIP program as a flashpoint when positive changes in the healthcare landscape occurred. Community and clinical organizations recognized and joined the hospital's endeavor to address the Triple Aim of healthcare: better health outcomes, lower costs, and better patient experiences. Patients became more aware of their health and more educated on community resources. Screening levels increased and hospital readmission rates and chronic condition acuity decreased. The internal cost savings brought about by DSRIP, what one interviewee referred to as a soft metric of their project's economic value, became an allowable

revenue on the project budgets reported to CMS in the final demonstration years. An external observer described an overall success of DSRIP:

> *"despite some of the difficulties of DSRIP … a number of hospitals are going to continue to utilize the DSRIP changes in their programs …. Once DSRIP goes away they're going to continue those programs in place, so there's some value there that they saw once they made the changes."*

> *"the hope for DSRIP was to move the hospitals out into the community more, and eight years ago they weren't working with those community groups, the community healthcare groups that they are now. Even if there's a mixed bag of success, their focus is working a little bit more outside the four walls of the hospital, and that's a good thing, isn't it?"*

Topic	Round 1	Round 2	Round 3
Burden of reporting	Reporting requirements were seen as a significant burden that was unevenly distributed across hospitals and reporting partners due to differences between hospitals in the level of technology and the number of low-income patients.	Advocacy resulted in a reduction in some measures that hospitals found particularly burdensome, but reporting remained a significant and unevenly distributed burden, with hospitals with fewer resources (due to scale or focus on lower-income patients) having the highest burden.	Participants have accepted the necessity of reporting and were better equipped to do so, but still found that it took significant resources. Even with better technology, considerable staff effort was required to compute and validate measures, and the burden was heaviest on hospitals serving the poorest populations.

The requirement to report an excessive number of metrics was a common criticism across the DSRIP project and participants. Though this complaint attenuated during the project, the task required large amounts of resources to track and produce reports for substantial time and effort to analyze. Interview participants agreed that data were a potential source of knowledge, but also felt such data did not fulfill this function unless significant insights or actionable recommendations were shared. Aside from the numerous variables to collect, the relevancy to specific programs or populations was often not clear. There was also concern that the cost burden of reporting and the uncertainties of dealing with patient attribution lists would sap hospital resources that could otherwise be used to improve care. Some programs within larger health systems benefited from corporate support with respect to defining and calculating metrics.

"Well, the thing of it is what I kept trying to tell everybody is just take a deep breath, calm down and get the right people at your hospital sitting down. Because if everybody can calm down, like for example, and I'm just going to throw this out, the hospital already had public reporting and we use a vendor ... Well, you could use them too . . ."

"The attribution list is overwhelming. And again, we have our analyst, that it takes weeks and weeks and weeks. And we have had to partner with an additional outside agency that is extremely expensive to look through the data for us, because it's an enormous amount of data."

"[There was an] an added step where we had to, now, list all of the patients for each measure. And between our hospitals and our reporting partners and all of the chart reviews that we had to do, the addition of that step was tens of, maybe not hundreds of hours, additional, which ... I couldn't really go to the hospital administration and say, "Oh, here's a new requirement. I need more staff." Because they would've been like, "Yeah. Tough." "

Moreover, there was still a sense among many interviewees that data reporting requirements had taken resources away from clinical care. Several hospitals discussed the administrative burden of reporting:

" . . . one of the challenges of the DSRIP program was the complexity with reporting and all the different requirements. They really required a lot of staff and administrative time to figure out to meet those goals, and aside from patient care. "

"It was onerous. Reporting was really onerous. And other work stopped so that we could get DSRIP in. It's really such a multidisciplinary team between finance and IT and infection prevention. So many different players that it was like the Wild Wild West. And then adding a whole other piece made ... That was a huge challenge for us."

"Way too much time spent reporting to DSRIP that could have been spent on program development and implementation. Like we said a couple times already, the reporting process is cumbersome and our whole world stops while that happens, because it has to get done, the deadline is there, there are lots of extra hours put in and it just stops. There are lots of late night phone calls, it's too much data to report out, and it's not, in my opinion, a true representation of the data...."

"[Demonstration years] six through eight, when there were some new measures implemented and there were some changes, it took quite a while I think, and even in the most recent reporting year, some of our sites were still struggling with having a really good foothold and understanding of the data and getting access to that data, whether it

was internally or with their partner organization and being able to interpret it, that kind of thing."

Topic	Round 1	Round 2	Round 3
Value of reporting and performance assessment	Reporting is an important component of the program tied to payments, yet many participants are unsure of the value of measures to be reported.	Participants continued to question measures in both the project-specific component and the universal component, as well as the construction of the attribution model, which most seemed to feel was insufficiently transparent.	Though more value was seen in this round, participants continued to question measures in both the project-specific component and the universal component. Participants still found a lot of turnover in their attributed patients and were unable to use anonymized state-provided Medicaid metrics to target care improvements, and the delay in receiving feedback limited their ability to use the information to improve. Participants were concerned about the methods of assessing performance, including those potentially disadvantaging high performers.

Interviewees continued to recognize the value of reporting and translating operational performance into financial goals. Furthermore, they acknowledged that the measures can help identify gaps in care, if any exist. However, questions persisted regarding the reasons for reporting measures beyond those related to their specific interventions, and the selection process for such measures. Many claimed they had asked and had not received an answer. In some cases, the measures are collected for other purposes such as accreditation or hospital reports to CMS, but interviewees related that in other cases the measures required by the DSRIP program have been dropped by other reporting stewards, leading interviewees to question the value for this program. In April 2015, CMS approved a reduction in the number of measures after reviewing recommendations from the NJ Hospital Association (Fishman 2015).

There were also other issues mentioned with the way that performance results were calculated from the data, with a particular concern articulated that hospitals that were already high performers were penalized for small backslides that could be caused by just a few patients, while low performers who demonstrated an improvement that still left them relatively low in the performance hierarchy would be rewarded. Interviewees in the second round seemed to feel that concerns raised about this were addressed, though they were not all satisfied with the time that elapsed in addressing the issue. However, this issue was raised again in the third round of interviews. One participant commented,

"…the financial impact of the outcome measures that we have. I found that the way it was set up is that there was some opportunity there for improvement [in assessment methods] in regards to if you already had a metric that you achieved like 100%, and sometimes it's very challenging to maintain that, so the following year you had one fallout, so therefore financially was impacting you by $[200,000-300,000]. So that was kind of a disheartening find when we were going through our metrics and we identified that that was a major issue and a major flaw in the program itself because you're penalizing an organization for, you're doing really well and then unfortunately you have one fall out, so the impact financially was pretty high."

In addition to the universal metrics, some hospitals previously reported concerns about the metrics that were used in their chronic disease interventions, specifically that some follow-up care metrics were constructed in a way that missed some types of care, limiting their ability to assess important domains of care. Some participants also felt that, in retrospect, it was easier to meet the metrics in some interventions. In a previous report, one interviewee in a position to have seen the metrics from a large number of projects did not necessarily see this pattern, noting that none of the projects appeared easy; however, another interviewee who had seen a number of different projects did feel that they were not equitable. In the third round of interviews, one reported identifying a population health issue to which they were able to respond because of the universal metrics, while others still emphasized the heavy burden involved:

"And when DSRIP started to come out with MMIS measures, because I never saw any of those before either, I mean like, where are they from? Where we started to see, like [measure] rates that were so off the mark … we opened up a [related] program because we knew that nobody else was stepping up to the plate and we expanded, now it's not part of DSRIP. It is in our [partner] but we expanded the bookends of the life cycle truly, and now to this day, and it really is because of DSRIP."

"So that really put a challenge to us because we had to utilize a lot of staff to manually abstract charts and to validate, so that was a major concern for us and the hours that we spent doing that. Also the MMIS data, we were unable to validate the reliability of that data and identify any opportunities for improvement"

Topic	Round 1	Round 2	Round 3
DSRIP program administration	The program's evolving nature and delays in the finalization of approvals and details caused anxiety and confusion.	Communication with CMS remained an issue throughout the program, and some hospitals experienced significant delays in accessing funds during appeals. Levels of anxiety and confusion seemed lower in our second round of interviews, but satisfaction with the administration of the program was low in both rounds of interviews.	Participants seemed happy with program management provided by a new consulting group. While there were still delays in finalizing/accessing payments which caused budgetary uncertainties, participants had become used to this. Some hospitals thought there were ways the State could have been more helpful.

The complexity and ever-evolving nature of the DSRIP program was a consistent challenge for hospitals across all years of the program. Dissatisfaction with program administration was particularly acute in the first round of interviews, especially among safety-net hospitals with already tight budgets and a more significant financial stake in the program. In our second round of interviews, even though many initial uncertainties had been clarified, there was still dissatisfaction in the amount of time that hospitals had to wait to learn the results of appeals, which caused revenue uncertainties. There was also uncertainty about the future of the DSRIP as the first five years of the Demonstration came to a close, leaving hospitals in limbo with respect to staffing and carrying on their interventions without knowing whether the final demonstration years would be approved.

In our third round of interviews, while still present, dissatisfaction with DSRIP's administration had become less of an acute sentiment. This could partly be due to the maturity of the program, but several hospitals made mention of the new consulting group that managed DSRIP during the last two demonstration years. As the contract with the original consulting group neared completion, the New Jersey Department of Health engaged a new DSRIP consultant after a required and formal bidding process. Though both vendors executed their responsibilities well, as reported by a nonhospital observer, hospital participants noted a change in performance and style that most felt was for the better.

> One interview participant offered, *"… but I will say there was a year with the previous analyst crew where the numbers were not right, significantly not right. And money was at stake, a lot of money, and they never really gave an answer as to why or what happened. So confidence wise, in that previous group, I would have had some concerns."*

Another participant described, *"[second group] was stronger in their presentation of these collaboratives and involving the hospitals. That was one bigger change. They also have the benefit of being later on. [Initial group] took more slings and arrows in the beginning."*

Another participant commented, *"I think [second group] did a much better job of explaining a lot of the particulars, especially the technical details of reporting than we had previously had with the other consultants."*

Generally, the participants were appreciative of the consultant support since there was a constant need for education and communication to understand what was expected of them in the program. One hospital wished a support line could have been set up to get quicker answers to questions instead of having to wait days for email responses, especially when faced with reporting deadlines.

In this round of interviews, participants still noted structural problems with DSRIP's administration which caused frustrations. Some hospitals noted that the Department of Health (DOH) tried to keep participants apprised of pending changes to reporting and payment mechanics, but information often could not be shared in a timely manner since the State had to wait on CMS for final decisions. These delays, which were a problem since the beginning of DSRIP, persisted during the extension period. Also, achieving full transparency in performance payment calculations for metrics the State calculated on behalf of hospitals was precluded by privacy requirements. An external observer noted one problem that *"so much of the data was blind to the hospitals... hampered hospitals being able to adjust their program and their delivery of care to improve."* A safety-net hospital with a lot of Medicaid patients expressed disappointment in the anonymized performance reports they received that limited their opportunity to identify ways to improve: *" the MMIS report … We couldn't validate it. We're the type of organization where we'd like to … drill down, to identify if there's any opportunities for improvement to see where we are and where we need to be. But when you get a flat rate of percent and that's budgeted for you, that's kind of disheartening because you don't have the background to really take a deep dive in it…to get that drilled down to the patient identifiers to identify what it is that we're looking at."*

Safety net hospitals again raised attribution rosters as an issue with DSRIP administration in this round of interviews. They felt by the time they received the lists they were so far into the performance period that, if they could even find the patients on the list, it was too late to target that patient so that the intervention would benefit them in a measurable way:

"…The quality of this patient attribution and also the timing of receiving the attribution, all had a negative spin on that in terms of when we were receiving it. By the time you receive attribution, you're already half way up the performance year…The whole patient attribution is predicated on a false premise. One, the patient is willing to be engaged and two, it's easy to find the patient."

"We struggled with trying to get our attributed patient list on many occasions, especially when it would come out just prior to all the data being required. So they were some major challenges that we just didn't have control over, and I guess that's one of the biggest difficulties was things that you can't control."

The unpredictability also extended to payment determinations. One observer noted that DSRIP funding represented a large amount of funding for some hospitals and that the uncertainty of waiting for results and the potential funding shifts based on differential performance made their financial planning difficult, and that this continued throughout the program: *"it takes so long for them to find out how they're doing, which tells them how much money they're going to receive. ... for future budgeting … that made it difficult for the hospitals…. In the beginning, it was really strong growing pains. … they had to get use to the fact that they really might not get the money that they were banking on, because in the end it was based on performance. … it was always a challenge, and then depending on how many metrics would fail how many hospitals, the money that gets thrown into the UPP, some hospitals woke up and it was like, "Wow, they really got rewarded this year because of circumstances that other hospitals have too many challenges." So I think it was an anxious program every year for these hospitals."*

Aside from program design and timing issues, some interviewees felt there were places where the State could have done more to help hospitals, but didn't take a proactive approach. For example, one non-safety net hospital thought the State could have publicized the program to communities more, so as to prime participation for the hospitals. On the other hand, there was mention of improved communication with hospitals on the part of the State and the consultant in the last demonstration years by means of an emailed newsletter, as opposed to the earlier and less helpful practice of simply posting relevant guidance documents on the DSRIP website and expecting hospitals to find them.

Topic	Round 1	Round 2	Round 3
Learning Collaboratives (LC)	Participants spoke very positively of the Learning Collaboratives.	Many participants spoke positively of the Learning Collaboratives, though some who felt repeatedly tapped for expertise were less sure that it was a good use of their time, and there was frustration at the lack of opportunity to question CMS directly. Some participants developed their own collaboratives involving more frequent communication.	Enthusiasm waned a bit for the Learning Collaboratives compared to previous rounds, particularly for those with long travel times. Still, participants found peer collaboration valuable and drew upon relationships formed in the LCs in their ongoing work, and also felt the LCs frequently provided useful information.

Opinions of the Learning Collaboratives continued to vary during the DSRIP extension period. As reported earlier in the DSRIP performance period, the collaborative meetings continued to provide participants a chance to network with others working on similar projects, sharing information and knowledge, and providing peer support. Interviewees felt that the knowledge exchanged through the Learning Collaboratives would help participants improve their chronic disease management programs and improve consumer health. However, more recent evaluations of the Learning Collaboratives yielded more disappointments. The lack of data synthesis and sharing were perceived to be flaws in the event's purpose of learning. Some were frustrated in that CMS was not available for questions at the collaborative meetings, meaning that state officials or the contractor for the program had to note questions, then ask CMS and respond in future meetings. Discussion of future funding or DSRIP activities were generally vague. While some enjoyed the opportunity to get away from their regular routine and mingle with colleagues, others questioned the value of in-person meetings and webinars citing the time and effort necessary for travel across the state and staffing changes necessary to maintain program operations. Some groups created their own collaboratives for more frequent discussion, either based in a geographic region or in a type of intervention.

Following are a few quotes critical of the LCs regarding lack of emphasis on findings from all the data collected, the time burden for some to attend, and the lack of opportunity to get immediate answers:

> *" . . . over the last three years they could have spent more time in those learning collaboratives, actually sharing data and lessons learned. . . .. And we never got back any of that from the state. Once in a while you'd get maybe a bar chart showing different hospitals in this state and how they performed on a particular metric, but you never got*

anything resembling, "Hey, here's the story …" Let me tell you a story from the 8 million bits of data we just got here, we never got that, let alone a conclusion for many of it. So I think that's been the big failure of DSRIP. And if the state was going to invest anything it would be to get someone to go through that mountain, the eight years of data and try to make heads or tails out of it and tell a story about New Jersey experience."

"I wouldn't say they weren't helpful. However, I think that, and I'm going to speak for our group here, that it really took a lot away from a day of productivity within the office to drive... to discuss things that could have been put in a webinar. It was nice to meet other hospitals, but that could be a one time "Hey, how are you doing? Blah, blah, blah." But because everybody was doing something different, I really didn't feel that it was that informative to attend."

"One thing that came up consistently in each of the learning collaboratives were, there were a lot of questions about the future of the program, and most of the time they were not able to answer it within that learning collaborative. It was always, "We have to get back to you. We'll give you a response."

On the other hand, one observer noted a positive spirit of collaboration in the LCs: *"for the most part it was the clinical social program people, and they were all excited about this ... Every quarterly meeting we would have some hospitals present their results. You could see how excited they were to help people. And sharing, you could see it across the different hospitals, these people were excited for each other … It's a very competitive industry, and I think it was very positive experience … to see a competitive industry come together … and cooperate."*

There were also positive comments regarding the LC as a motivational and networking tool:

"So we just kept raising the bar and DSRIP was designed at least from my experience, that wherever you are, you got to get a little bit better and you got to get a little bit better and we didn't know any other way to do that, except to help each other and learn from each other."

"I will say, we had a learning collaborative very early on where we actually went into work groups with the other facilities that were doing the same project as we were. That learning collaborative was very helpful, where we were actually talking to the other hospitals that were doing the same projects as us and discussing how were they doing things, how were they implementing things. "

Topic	Round 1	Round 2	Round 3
Effect of concurrent policies	The effect of concurrent policy developments on DSRIP program objectives was uncertain.	Most participants seemed to feel that concurrent policy developments were either neutral or supportive, though they worried about the effects of future federal policy developments, such as any retrenchment of the Medicaid expansion.	Round 3 interviewees were not explicitly asked about concurrent policy developments, and none brought up the topic.

In many ways, concurrent policy developments such as the expansion of Medicaid, Medicare penalties for excess readmissions, and the formation of accountable care organizations, reinforced similar principles as the DSRIP. Our third round interview guide did not explicitly ask about this as we had in previous rounds, and our interview participants did not mention this topic.

In our second round we heard that Medicare penalties for readmissions disproportionately affected safety net hospitals. In 2019, the formula for penalty calculation was changed to compare hospitals to their peers rather than to an overall average, which meant a decrease in penalties for safety net hospitals (McCarthy et al. 2019).

Suggestions for future rounds of DSRIP

In all three rounds of interviews, stakeholders had suggestions for improvements to future rounds of DSRIP-like programs. They are summarized by topic in the table below.

Topic	Round 1	Round 2	Round 3
Participants	Some thought participation should be restricted to safety net hospitals.	More thought that participation should be restricted to safety net hospitals for sake of equity (more need for those hospitals) and efficiency (hard to create interventions for small low-income populations served by non-SNHs)	Less mention of restricting participants but many mentions of the social determinants of health that may have differential impacts on different hospitals, and a desire that such factors should be taken into account in design and selection/calculation of measures.
Measures	• Have a smaller set of reporting metrics with a clearly defined	Measures should be focused, fair (i.e., not penalize high performers who	• Universal desire for a smaller number of measures

	purpose (i.e., how will data be used to improve care) • Monitor attribution model to ensure consistency	experience a small setback), transparent and provide real-time feedback to allow participants to respond quickly. Measures should also be aligned with other payers.	• Consideration of risk adjustment for hospitals serving different populations • Calculation of performance should be reasonable (i.e., not require improvement each time, since there is a ceiling of possible achievement and inevitable setbacks) • Assessment should be provided in a timely fashion and with enough detail to allow response.
Program design	• Finalize requirements before rollout • Involve outpatient partners in program development	Wide involvement of industry in program development (not just associations), including outpatient partners.	Desired engagement of hospitals and outpatient partners in design.
Resources	Resources should be set aside for outpatient partners.	Assistance with information technology should be provided to hospitals/partners who lack resources, to ensure better health information tracking and exchange ability. Additional resource provisions should be made for outpatient partners.	• Consideration should be given of the resources required to compile measures. • All desired participants (inpatient, outpatient) should be incentivized to participate.

Participants/Measures. We did not hear calls in our third round of interviews that a DSRIP-like program should only be open to safety net hospitals, but we did hear a lot about how various social determinants of health affected safety net hospitals disproportionately. Participants serving patients with resource constraints that affected patients' ability to manage their own health wanted to see this taken into account, as was done in the segmentation of Medicare readmission penalties in 2019 (McCarthy et al. 2019): *"the safety net hospitals, in particular, took the biggest hit from DSRIP. If you look at metrics and you look at the amount of money that hospitals got, the safety net hospitals were always at the bottom because, again, it has to do with*

the patients that you're taking care of and the disadvantages to them as an underserved population. I think that certainly nationally, hopefully, there is a better understanding of how social determinants of care, or I would just say lack of resources, impacts peoples' health state. I think that the safety net hospitals in the DSRIP program were penalized based upon the types of patients that we were trying to care for, that there was no level playing field as the DSRIP program was set up. … still yet to be determined for the QIP-NJ program."

One safety-net hospital noted that participation in the program was really not voluntary for them: *"It was never an opportunity to bow out of the project for the safety net hospitals. You have to participate … I'm not saying that the state says you have to participate, or CMS says you have to participate. They'll tell you it's a voluntary program … But from an organizational standpoint, it's not voluntary when it means that you're going to lose all that money."* We can see in Table 1 that safety net hospitals, whether strictly defined as the 15 Hospital Alliance members or including additional former Hospital Relief Subsidy Fund recipients, had much more funding at stake with DSRIP than the 19 other hospitals—more than 9 times as much, whether looking at the total amount or the per bed amount. While these hospitals also make more from the state's charity care program, they still struggle to provide resources for patients. Several hospitals reported using their own funds to provide resources such as food or other supplies for patients enrolled in their DSRIP programs, rather than using their DSRIP funds. There isn't a single metric that captures patient needs that strain hospital resources. For example, in addition to poverty, some areas of New Jersey have much more linguistic diversity than others. One interviewee also argued that the state should pay attention to people with intellectual and developmental disabilities, particularly those 21 and over who are not eligible for assistance through the school systems.

As shown in Table 3, New Jersey counties vary a great deal in their population of limited English speakers, which poses varied challenges for hospitals serving these populations. The estimated number of limited English-speaking households ranges from 520 (1%) in Cape May County to 38,593 (15%) in Hudson County. The extent to which limited English speaking households speak Spanish varies from a high of 92% in Cumberland County to a low of 30% in Burlington County, with the number of limited English-speaking households speaking something other than Spanish ranging from 139 in Salem County to 20,377 in Bergen County. The number of languages spoken also varies by county—9 counties have 1-2 language groups[6] with 1,000 or more limited English speakers ages 5 and over, 8 counties have 4-9 such language groups, and 4 counties have 10 or more language groups with 1,000 or more limited English speakers. This poses much greater challenges for providers in these counties in terms of communication with their patient

[6] Some languages (e.g., German) are broken out individually, while others (e.g. Scandanavian languages) are grouped.

populations. While one interviewee was able to meet their population's needs by having bilingual (English/Spanish) materials and staff, another interviewee noted that their hospital serves populations speaking several dozen different languages, and that communicating and providing culturally competent care with this diversity of people is very resource-intensive.

Table 3: Limited English Speakers in NJ Counties

County	Number of limited English-speaking households *	Percent of households that are limited English-speaking*	Number of limited English-speaking households that speak Spanish*	Percent of limited English-speaking households that speak Spanish**	Number of limited English households speaking other than Spanish**	Number of language groups with 1,000 or more people over age 5 who speak English less than very well***
Atlantic	5,504	5.5%	3,144	57.1%	2,360	5
Bergen	30,180	8.9%	9,803	32.5%	20,377	19
Burlington	3,182	1.9%	967	30.4%	2,215	2
Camden	9,400	5.0%	6,135	65.3%	3,265	5
Cape May	520	1.3%	351	67.5%	169	1
Cumberland	3,808	7.5%	3,488	91.6%	320	1
Essex	28,231	10.0%	17,809	63.1%	10,422	10
Gloucester	1,438	1.4%	489	34.0%	949	1
Hudson	38,593	15.1%	27,243	70.6%	11,350	13
Hunterdon	868	1.8%	485	55.9%	383	1
Mercer	9,264	7.1%	5,451	58.8%	3,813	5
Middlesex	23,889	8.4%	11,315	47.4%	12,574	17
Monmouth	8,283	3.5%	3,928	47.4%	4,355	7
Morris	8,123	4.5%	4,240	52.2%	3,883	7
Ocean	4,519	2.0%	2,036	45.1%	2,483	2
Passaic	19,819	12.1%	15,429	77.8%	4,390	9

Salem	613	2.6%	474	77.3%	139	1
Somerset	5,174	4.4%	2,154	41.6%	3,020	4
Sussex	839	1.6%	314	37.4%	525	1
Union	22,841	12.1%	16,635	72.8%	6,206	9
Warren	1,092	2.6%	662	60.6%	430	1
New Jersey	*226,180*	*7.0%*	*132,552*	*58.6%*	*93,628*	

Sources: *US Census Bureau, American Community Survey 2018 5 Year Estimates, Table S1602; **Author's calculations from S1602; ***Author summary of data from US Census Bureau, American Community Survey 2015 5 Year Estimates, Table B16001

In addition to the issue of adjusting for populations served, interviewees wanted to ensure that the calculation of rewards or penalties did not unduly penalize high performers. For example, one interviewee discussed earlier (p.17) who had the large fallout because of a small retrenchment on one measure said: *"So hopefully in the future … methodology to align and give you at least some type of percentage that you're still doing very well above the national rate of others. But because you fell out one case, that's a substantial decrease in our financial budget … if you've achieved or if you've improved, you've got a percentage. Not just completely, "Sorry, you get nothing.""*

Another observer discussed the complexity of designing measures fairly: *"there's so little room to move that needle, that the amount of resources you're going to have to add for that high performer, it just wasn't feasible. And then there was small denominator and small numerators that affected a wide swing. You're talking a move of one or two patients. So there was some things that we learned that were not practical, and kind of put the hospitals at a disadvantage."*

Overall, then, while the concept of pay-for-performance was accepted, participants thought there may need to be adjustments to the method of calculating rewards or penalties. Participants also thought there should be a reasonable number of focused metrics to minimize the administrative burden of calculating them and to ensure that resources could be directed toward improvement for those metrics.

Program design/Resources. A consistent theme through all three rounds of interviews is that there should be broad stakeholder engagement in designing a new program, including outpatient partners if their input was desired. There were also some timing issues with DSRIP where hospitals didn't feel they had enough time to make applications, or were not notified of the acceptance of their applications in time to implement their proposals.

Most enrollees seemed cautiously optimistic about the new QIP-NJ, though they knew little about it and were interested to know more about program design and measures. There was some concern expressed that not all hospitals had maternity programs, and that all patients needed support with transitions: "*a true transition to care program, and that's really what I think this new wave should be, and it shouldn't just be for labor and delivery … it should be for every patient that either goes through the ED and or the hospital should have an option to have good transition to care leaving*."

With regard to behavioral health, there was some concern expressed that hospitals did not have the resources needed to tackle these important issues: "*if we're talking behavioral health, we're going to need more help, but not just as an organization, we're going to have to get help from the state. Because there's a lot of programs that are required in the behavioral health world, that there's not enough of resources out there. So I would like to see some support from the state to help guide us in regards to that.*"

Conclusion

The third round of stakeholder interviews in our evaluation of New Jersey's DSRIP program reinforced themes found in previous rounds with some added insights reflective of the program's maturity. As previously reported, participants continued to be enthusiastic about chronic disease management interventions. By the second round of interviews, most reported positive effects on the care and health of patients they served. In the third round, these positive outcomes were again emphasized with many hospitals desiring to continue their interventions despite the conclusion of DSRIP in June 2020. Stakeholders generally could not say how overall costs were affected in this or previous rounds, but there were a number of reports of reduced readmissions, emergency department visits and shorter hospital stays.

Partnerships with community organizations were positively reviewed by many, but difficulty establishing data reporting relationships with clinical partners was still a repeated complaint in this round of interviews. Hospitals generally remained unsatisfied with reporting requirements, particularly with respect to the universal metrics, and also in some cases with the project-specific metrics when they felt that the metric did not fairly represent outcomes. Several also communicated that performance assessment was influenced by uncontrollable factors like the attribution roster or potential variability due to small numbers of patients on whom metrics were based. With the universal metrics (reported for all attributed patients), many participants found them to be a significant burden and also questioned the purpose or value of reporting those

metrics. Still, by this third round, it was apparent that hospitals had found ways to adapt to the reporting burdens and do their best complying with this requirement.

The Learning Collaboratives (LCs) were still generally viewed as positive with a number of hospitals complimenting the State's new consultant helping to administer the program, but we found some waning in the perception of the LCs' value among stakeholders in this round. Participants offered suggestions for future rounds of DSRIP-like programs, including paring down required metrics, risk-adjusting measures for population factors, involving hospitals and outpatient partners in program design, and devoting more resources to outpatient partners and information technology.

The DSRIP successor program, QIP-NJ, is scheduled to begin in 2021. This program will focus on maternal and behavioral health. The standardization of efforts towards common goals across all hospitals under the QIP-NJ program would be a significant departure from the DSRIP model. It would eliminate hospital choice of focus area, which could dampen the enthusiasm we consistently heard across all hospitals and interview rounds for chosen chronic disease management projects. However, this alignment could better allow for measuring industry-wide progress in achieving population health improvement goals, providing more feedback on relative performance to hospitals for their intensive reporting efforts.

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Appendix A: Interview Question Guides, Round One Interviews

DSRIP Interview Question Guide, Participating Hospitals

As you know, the NJ DSRIP program introduces a hospital incentive payment system based on pay-for-reporting and pay-for-performance. The program's objective is to improve access and quality of care in communities served by hospitals participating in the DSRIP program, resulting in better health and lower costs. Our questions relate to the experience of hospitals participating in these programs and perceptions of the program's potential to improve access, healthcare and health.

1. **What are the hospital experiences to date in understanding the DSRIP program requirements?**
2. **What are the hospital experiences to date in implementing the initial requirements of the DSRIP program relating to application, approval, planning and other early implementation processes?**
3. **Do the hospitals feel that the DSRIP program will facilitate their ability to improve access and quality of care? If so, do they feel these improvements will result in positive effects on population health?**
4. **What specific components of the program, if any, will make the greatest contribution to promoting one or more of the triple aims: better care, better health, and lower costs? Which of the triple aim(s) will the program promote? Can you give some specific examples of program components that will promote the aims?**
5. **Similarly, what program requirements/characteristics, if any, pose challenges to participating hospitals in terms of implementation and consequently achieving the desired outcomes?**
6. **Among the eight chronic disease project areas, are there some that offer the greatest potential for improvement through this program? Which ones?**
7. **What improvements in care and health, if any, have already been noted in your communities as a result of the DSRIP activities?**
8. **What problems in care and health, if any, have already been noted in your communities as a result of the DSRIP activities?**
9. **Will other concurrent policy changes (e.g., Medicaid expansion, readmission penalties, ACOs) impact DSRIP activities or outcomes? If so, in what ways?**

10. **What has been the experience of the hospitals related to the learning collaborative and rapid cycle improvement tools? Have these program features aided in the process of project implementation and advanced DSRIP health improvement goals? If so, in what ways?**
11. **Is there anything else that we should know about hospital experiences and potential of the DSRIP but have not asked about?**

DSRIP Interview Question Guide, Nonparticipating Hospitals

As you know, the NJ DSRIP program introduces a hospital incentive payment system based on pay-for-reporting and pay-for-performance. The program's objective is to improve access and quality of care in communities served by hospitals participating in the DSRIP program, resulting in better health and lower costs. Our questions relate the experience of hospitals and other stakeholders participating in these programs and perceptions on the program's potential to improve access, improve health and lower costs.

1. **Our understanding is that your hospital, along with several others, chose not to participate in DSRIP. What factors would you say led to your decision not to participate?**
2. **How involved did you get in the process before deciding not to submit an application?**
3. **What do you think about the potential of the DSRIP program to improve access and quality of care in the state as a whole? Do you think it could improve population health? How relevant is this to your own patient population?**
4. **What specific components of the program, if any, will make the greatest contribution to promoting one or more of the triple aims: better care, better health, and lower costs? Which of the triple aim(s) will the program promote? Can you give some specific examples of program components that will promote the aims?**
5. **Similarly, what program requirements/characteristics, if any, pose challenges to participating hospitals in terms of implementation and consequently achieving the desired outcomes?**
6. **Among the eight project areas, are there some that offer the greatest potential for improvement through this program? Which ones?**
7. **What improvements in care and health, if any, have already been noted as a result of the DSRIP activities?**
8. **What problems in care and health, if any, have already been noted as a result of the DSRIP activities?**
9. **Will other concurrent policy changes (e.g., Medicaid expansion, readmission penalties, ACOs) impact DSRIP activities or outcomes? If so, in what ways?**
10. **In terms of future program design, what kinds of changes would make you more likely to participate?**
11. **Is there anything else that we should know about hospital experiences and potential of the DSRIP but have not asked about?**

DSRIP Interview Question Guide, Nonparticipating Hospitals (Withdrawn)

As you know, the NJ DSRIP program introduces a hospital incentive payment system based on pay-for-reporting and pay-for-performance. The program's objective is to improve access and quality of care in communities served by hospitals participating in the DSRIP program, resulting in better health and lower costs. Our questions relate the experience of hospitals and other stakeholders participating in these programs and perceptions on the program's potential to improve access, improve health and lower costs.

1. **Our understanding is that your hospital initially participated but then withdrew from the program. What factors would you say led to your decision to withdraw?**
2. **How involved did you get in the process before deciding to withdraw? How difficult was it to arrive at that decision?**
3. **What do you think about the potential of the DSRIP program to improve access and quality of care in the state as a whole? Do you think it could improve population health? How relevant is this to your own patient population?**
4. **What specific components of the program, if any, will make the greatest contribution to promoting one or more of the triple aims: better care, better health, and lower costs? Which of the triple aim(s) will the program promote? Can you give some specific examples of program components that will promote the aims?**
5. **Similarly, what program requirements/characteristics, if any, pose challenges to participating hospitals in terms of implementation and consequently achieving the desired outcomes?**
6. **Among the eight project areas, are there some that offer the greatest potential for improvement through this program? Which ones?**
7. **What improvements in care and health, if any, have already been noted as a result of the DSRIP activities?**
8. **What problems in care and health, if any, have already been noted as a result of the DSRIP activities?**
9. **Will other concurrent policy changes (e.g., Medicaid expansion, readmission penalties, ACOs) impact DSRIP activities or outcomes? If so, in what ways?**
10. **In terms of future program design, what kinds of changes would make you more likely to participate?**
11. **Is there anything else that we should know about hospital experiences and potential of the DSRIP but have not asked about?**

DSRIP Interview Question Guide, FQHCs

As you know, the NJ DSRIP program introduces a hospital incentive payment system based on pay-for-reporting and pay-for-performance. The program's objective is to improve access and quality of care in communities served by hospitals participating in the DSRIP program, resulting in better health and lower costs. Our questions relate the experience of hospitals and other stakeholders participating in these programs and perceptions on the program's potential to improve access, improve health and lower costs.

1. **What are the FQHC experiences to date with the DSRIP program?**
2. **Do the FQHCs feel that the DSRIP program will improve access and quality of care with positive effects on population health? How would the hospitals and the outpatient partners contribute to achieving these aims?**
3. **What specific components of the program, if any, will make the greatest contribution to promoting one or more of the triple aims: better care, better health, and lower costs? Which of the triple aim(s) will the program promote? Can you give some specific examples of program components that will promote the aims?**
4. **Similarly, what program requirements/characteristics, if any, pose challenges to participating hospitals/FQHCs/partnerships in terms of implementation and consequently achieving the desired outcomes?**
5. **Among the project areas (asthma/pneumonia, behavioral health/chemical addiction/substance abuse, cardiac care, diabetes and obesity) are there some that offer the greatest potential for improvement through this program? Which ones?**
6. **What improvements in care and health, if any, have already been noted in your communities as a result of the DSRIP activities?**
7. **What problems in care and health, if any, have already been noted in your communities as a result of the DSRIP activities?**
8. **Will other concurrent policy changes (e.g., Medicaid expansion, readmission penalties, ACOs) impact DSRIP activities or outcomes? If so, in what ways?**
9. **As a part of the DSRIP process hospitals are involved in learning collaboratives and rapid cycle improvement tools. Are FQHCs involved in these hospital-related activities in any way?**
10. **Is there anything else that we should know about FQHC experiences related to the DSRIP program, but have not asked about?**

Appendix B: Interview Question Guides, Round Two Interviews

DSRIP Interview Question Guide, Participating Hospitals

For Hospitals

1. **What was your role or association in regard to the DSRIP program? How long have you been associated with the program (e.g., from initiation, or any other time)?**

Quality of care

2. **What changes – either improvements or new problems – if any, occurred in in the communities you serve as a result of the DSRIP activities (observed by your organization directly, or by others)?**
    a. Did these effects vary across different groups of patients and communities?
    b. Which patients or communities were impacted the most?
    c. Were there new clinical and community partnerships formed as a result of the DSRIP program, (please describe them)?

Cost/Efficiency of care

3. **Has the DSRIP program impacted, positively or negatively, efficiency of care? (An increase in efficiency would amount to a decrease in the cost of care without compromising quality)**

Care and Efficiency Drivers

4. **What specific components of the program, if any, were most effective in promoting one or more of the triple aims: better care, better health, and lower costs?**

5. **What specific components, if any, posed the greatest challenges to hospitals in promoting these aims?**

Implementation Difficulties

6. **In our first round of interviews, several challenges (faced by hospitals) were mentioned both due to difficulty in understanding of DSRIP requirements and also constraints faced in implementation. These included outpatient partner requirements, data reporting and EMR capability issues, and attributing populations to hospitals.**
    a. Do you agree that these were problems early in the program?
    b. Are there other early problems that I did not mention?

7. **Did these problems (understanding program requirements and implementation difficulties) persist?**
    a. Were there issues to note other than these?
    b. Which strategies were the most successful in resolving these?
    c. (Note for Interviewer only) Note that some of the confusion may have been addressed by learning collaborative meetings, training webinars, interactions with government officials

Potential Resource Constraints

8. **There was a concern in the first round of interviews that DSRIP required hospitals to perform additional activities for the same amount of money, especially safety net hospitals.**
    a. Do you agree that this was a concern early in the program?
    b. Was there a change in this perception as the program was implemented over time?

9. **Were sufficient resources allocated for the various program activities?**
    a. What aspects were not taken into account?
    b. (Note for Interviewer only) Probe on outpatient partners.

10. **What was the impact of these additional activities on hospital operations, patient care and hospital finances?**

Learning Collaborative

11. **What has been the experience of the hospitals related to the learning collaborative and rapid cycle improvement tools?**
    a. Have these program features aided in the process of project implementation and advanced DSRIP health improvement goals? If so, in what ways?
    b. What could have made the learning collaborative more useful?

Future Rounds

12. **What suggestions would you have for future DSRIP or DSRIP-like programs both in terms of policy formulation and implementation?**

Other Information

13. **Is there anything else that we should know about hospital experiences, potential of the DSRIP, or patient care, cost and health, but have not asked about?**

DSRIP Interview Question Guide, Outpatient Partners

For Outpatient Providers/FQHCs

1. **Please describe the role played by your organization in the DSRIP program e.g., data sharing, coordination of care etc.**
    a. What was your role or association in regard to the DSRIP program? How long have you been associated with the program (e.g., from initiation, or any other time)?

Quality of care

2. **What changes – either improvements or new problems – if any, occurred in in the communities you serve as a result of the DSRIP activities (observed by your organization directly, or by others)?**
    a. Did these effects vary across different groups of patients and communities?
    b. Which patients or communities were impacted the most?
    c. Were there new clinical and community partnerships formed as a result of the DSRIP program, (please describe them)?

Cost/Efficiency of care

3. **Has the DSRIP program impacted, positively or negatively, efficiency of care? (An increase in efficiency would amount to a decrease in the cost of care without compromising quality)**

Care and Efficiency Drivers

4. **What specific components of the program, if any, were most effective in promoting one or more of the triple aims: better care, better health, and lower costs?**

5. **What specific components, if any, posed the greatest challenges in promoting these aims?**

6. **Can you specifically comment on the role played by hospital-FQHC partnerships in advancing DSRIP aims?**

Implementation Difficulties

7. **In our first round of interviews, several challenges were mentioned both due to difficulty in understanding of DSRIP requirements and also constraints faced in implementation. These included outpatient partner requirements, data reporting and EMR capability issues.**
    a. Do you agree that these were problems early in the program?
    b. Are there other early problems that I did not mention?

8. **Did these problems persist?**
    a. Were there issues to note other than these?
    b. Which strategies were the most successful in resolving these?
    c. (Note for Interviewer only) Note that some of the confusion may have been addressed by learning collaborative meetings, training webinars, interactions with government officials

Potential Resource Constraints

9. **Were sufficient resources allocated for the various program activities, including FQHC activities?**

Learning Collaboratives

10. **As a part of the DSRIP program, hospitals are involved in learning collaboratives and also adopted rapid cycle evaluation strategies for real-time improvement of their DSRIP projects. Have FQHCs been involved in these activities in any way?**

Future Rounds

11. **What suggestions would you have for future DSRIP or DSRIP-like programs both in terms of policy formulation and implementation?**

Other Information

12. **Is there anything else that we should know about your experiences, potential of the DSRIP, or patient care, cost and health, but have not asked about?**

Appendix C: Interview Question Guides, Round Three Interviews

DSRIP Interview Question Guide, Participating Hospitals

1. **What was your role or association in regard to the DSRIP program? How long have you been associated with the program (e.g., from initiation, or any other time)?**

Quality of care

2. **What changes – either improvements or new problems – if any, occurred in in the communities you serve as a result of the DSRIP activities (observed by your organization directly, or by others)?**
    a. Did these effects vary across different groups of patients and communities?
    b. Which patients or communities were impacted the most?
    c. Were there new clinical and community partnerships formed as a result of the DSRIP program, (please describe them)?

Cost/Efficiency of care

3. **Has the DSRIP program impacted, positively or negatively, efficiency of care? (An increase in efficiency would amount to a decrease in the cost of care without compromising quality)**

Care and Efficiency Drivers

4. **What specific components of the program, if any, were most effective in promoting one or more of the triple aims: better care, better health, and lower costs?**

5. **What specific components, if any, posed the greatest challenges to hospitals in promoting these aims?**

Implementation Difficulties

6. **In our earlier rounds of interviews, several challenges (faced by hospitals) were mentioned both due to difficulty in understanding of DSRIP requirements and also constraints faced in implementation. These included outpatient partner requirements, data reporting and EMR capability issues, and attributing populations to hospitals.**
    a. Do you agree that these were problems early in the program?
    b. Are there other early problems that I did not mention?

7. **Did these problems (understanding program requirements and implementation difficulties) persist?**

a. Were there issues to note other than these?
b. Which strategies were the most successful in resolving these?

Potential Resource Constraints

8. **There was a concern in the earlier rounds of interviews that DSRIP required hospitals to perform additional activities for the same amount of money, especially safety net hospitals.**
    a. Do you agree that this was a concern early in the program?
    b. Was there a change in this perception as the program was implemented over time?

9. **Were sufficient resources allocated for the various program activities?**
    a. What aspects were not taken into account?

10. **What was the impact of these additional activities on hospital operations, patient care and hospital finances?**

Learning Collaborative

11. **What has been the experience of the hospitals related to the learning collaborative and rapid cycle improvement tools?**
    a. Have these program features aided in the process of project implementation and advanced DSRIP health improvement goals? If so, in what ways?
    b. What could have made the learning collaborative more useful?

Future Rounds

12. **What suggestions would you have for future DSRIP or DSRIP-like programs both in terms of policy formulation and implementation?**

Other Information

13. **Is there anything else that we should know about hospital experiences, potential of the DSRIP, or patient care, cost and health, but have not asked about?**

DSRIP Interview Question Guide, Outpatient Partners/FQHCs[7]

1. **Please describe the role played by your organization in the DSRIP program e.g., data sharing, coordination of care etc.**
    a. What was your role or association in regard to the DSRIP program? How long have you been associated with the program (e.g., from initiation, or any other time)?

Quality of care

2. **What changes – either improvements or new problems – if any, occurred in in the communities you serve as a result of the DSRIP activities (observed by your organization directly, or by others)?**
    a. Did these effects vary across different groups of patients and communities?
    b. Which patients or communities were impacted the most?
    c. Were there new clinical and community partnerships formed as a result of the DSRIP program, (please describe them)?

Cost/Efficiency of care

3. **Has the DSRIP program impacted, positively or negatively, efficiency of care? (An increase in efficiency would amount to a decrease in the cost of care without compromising quality)**

Care and Efficiency Drivers

4. **What specific components of the program, if any, were most effective in promoting one or more of the triple aims: better care, better health, and lower costs?**

5. **What specific components, if any, posed the greatest challenges in promoting these aims?**

6. **Can you specifically comment on the role played by hospital-FQHC partnerships in advancing DSRIP aims?**

Implementation Difficulties

7. **In our earlier rounds of interviews, several challenges were mentioned both due to difficulty in understanding of DSRIP requirements and also constraints faced in implementation. These included outpatient partner requirements, data reporting and EMR capability issues.**
    a. Do you agree that these were problems early in the program?
    b. Are there other early problems that I did not mention?

[7] We attempted to recruit outpatient partners for this round but were not successful.

8. **Did these problems persist?**
    a. Were there issues to note other than these?
    b. Which strategies were the most successful in resolving these?

Potential Resource Constraints

9. **Were sufficient resources allocated for the various program activities, including FQHC activities?**

Learning Collaboratives

10. **As a part of the DSRIP program, hospitals are involved in learning collaboratives and also adopted rapid cycle evaluation strategies for real-time improvement of their DSRIP projects. Have FQHCs been involved in these activities in any way?**

Future Rounds

11. **What suggestions would you have for future DSRIP or DSRIP-like programs both in terms of policy formulation and implementation?**

Other Information

12. **Is there anything else that we should know about your experiences, potential of the DSRIP, or patient care, cost and health, but have not asked about?**

Appendix D: Interview Question Guides, Round Three Interviews

Table D.1: Recruiting/Completed Summary by Interviewee Region and Type (Numbers of Organizations)

Interviewee Region/Type	Round 1		Round 2		Round 3	
	Recruited	Interviewed	Recruited	Interviewed	Recruited	Interviewed
North-SNH	1	1	4	3	4	4
North-nSNH	1	1	1	0	2	1
Central-SNH	1	1	1	1	2	2
Central-nSNH	1	1	2	2	1	1
South-SNH	1	1	1	1	3	2
South-nSNH	1	1	1	0	5	4
Outpatient Partners	1	1	4	1	4	0
Others (state, associations)	4	4	4	3	3	1
Withdrawn Hospital	2	1	0	0	2	0
Nonparticipating Hospital	6	1	0	0	0	0
Total	*19*	*12*	*17*	*10*	*25*	*13*

Notes:

1) SNH=Safety net hospital (as defined by membership in the Hospital Alliance of NJ); nSNH=non-safety net hospital (nonmembers of Hospital Alliance of NJ).

2) Sometimes hospital interviewees represented both SNH and nSNH. In this case we have counted them in both categories, but we have not marked them as such in the table because of identifiability risk. For this reason, the number of interviewees noted in the rows of the table sometimes adds to more than the total number of organizations recruited or interviewed.

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