DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

Evaluation Report Acceptance Letter

January 17, 2025

Christine Osterlund
Medicaid Director
Department of Health and Environment
900 SW Jackson Avenue, Suite 900
Topeka, KS 66612

Dear Director Osterlund:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Kansas KanCare Delivery System Reform Incentive Program Summative Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC# 100 of Kansas's section 1115 demonstration, "KanCare" (Project No: 11-W-00283/7). This report covers the demonstration period from January 2015 to December 2020. In the context of the considerations outlined below, CMS accepts the evaluation report, dated May 28, 2021. In accordance with STC #103, the evaluation report may now be posted to the state's Medicaid website within thirty days. CMS will also post the evaluation report on Medicaid.gov.

The evaluation report highlighted the program's successes and strengths, including increased connections between hospitals and other providers, the creation of 18 telehealth sites, and physician practice site progress toward achieving National Committee on Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition. However, the report recognized that the evaluation is limited by the COVID-19 public health emergency (PHE) and lack of data and resources.

CMS expects that the state should devote its evaluation resources to the state's upcoming Summative Evaluation Report, due on July 1, 2025. We appreciate the states cooperation and commitment to robust evaluation of its current and future section 1115 demonstrations, and we look forward to continued collaboration.

If you have any questions regarding CMS's assessment of this evaluation report, or any aspect of your state's section 1115 demonstration, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S Digitally signed by Danielle Daly -S Date: 2025.01.17 11:57:14 -05'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

cc: Mai Le-Yuen, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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External Review
Expires 06/01/2024

Kansas Delivery System Reform Incentive Payment pool (DSRIP) Evaluation
May 28, 2021

The Delivery System Reform Incentive Payment (DSRIP) pool program is a component of the Kansas Section 1115 demonstration waiver, KanCare, which was approved for renewal from January 1, 2019 through December 31, 2023. The Kansas DSRIP projects were implemented in 2015 and extended through 2020. An Alternate Payment Model (APM) program will replace DSRIP. This updated evaluation reflects an additional two years of DSRIP assessment and a final overall evaluation summary. The State has used the insights gained from DSRIP when determining metrics to test during the 2021 Bridge year. Experiences from DSRIP and the Bridge year will help inform the development of the APM program, effective 2022.

The DSRIP program supported hospital efforts to enhance access to health care, quality of care, and the health of patients and families they serve. The program aimed to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals worked with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas included two hospitals, Children's Mercy Hospital (CMH) and the University of Kansas Health System (UKHS) that are major medical service providers to Kansas residents. The CMH projects were, "Expansion of Patient Centered Medical Homes and Neighborhood," and "Implementation of Beacon Program to Improve Care for Children with Medical Complexity (CMC)." The UKHS projects were "Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)," and "STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis." As the DSRIP funding was based on provision of services to Medicaid and uninsured Kansas residents, the approved metrics and the overall DSRIP evaluation focused on Kansas populations. KFMC Health Improvement Partners (KFMC) is the External Quality Review Organization (EQRO) for the State's Medicaid program (KanCare) and the independent evaluator of the DSRIP program.

UKHS and CMH had specific semiannual reporting requirements and timelines that were monitored by the Kansas Department of Health and Environment, Division of Health Care Finance, (KDHE-DHCF) and evaluated by KFMC. Reports were submitted to CMS accordingly.

The 2020 DSRIP year was impacted by the COVID-19 public health emergency, with UKHS, CMH, and their identified project participants focused on the pandemic response and ongoing non-COVID patient care. Patterns of availability and utilization of health care services were altered, and quality measure data collection and reporting were affected.

Furthermore, methods for collecting additional DSRIP evaluation data were impacted by the need to help reduce administrative burden for the DSRIP hospitals and identified project participants, as they focused on the pandemic response.

KFMC's evaluation has identified lessons learned and achievements from 2015 through 2020 for each project and the DSRIP program overall. Data sources included quantitative and qualitative data from the following:

- KFMC observations during pre-DSRIP implementation
- Hospital DSRIP semiannual and annual reports, 2015 – 2020
- KFMC DSRIP semiannual and annual evaluation reports, 2015 – 2019
- KFMC incorporated findings from evaluation of the hospitals' 2020 reports into this final evaluation.

The evaluation is structured by the phases of the DSRIP project, including:

- Pre-DSRIP implementation – program planning (including development of metric specifications, application templates, and reporting templates) and project proposal approval processes.
- Project implementation – learning collaborative and overlapping stages of defined activities and metrics (Appendix A):
  - **Infrastructure milestones (Category 1)** – laying the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
  - **Process milestones (Category 2)** – process changes and improvements.
  - **Quality and outcomes milestones (Category 3)** – Metrics associated with these milestones address the impact of the project on quality metrics and beneficiary outcomes.
  - **Population focused improvement milestones (Category 4)** – Metrics associated with the broader impact of the selected projects.
- Reporting and evaluation – DSRIP hospital reporting (semiannual and annual), State feedback, KFMC evaluation and recommendations, DSRIP hospital follow-up to recommendations, and overall DSRIP evaluation. This has been incorporated into KFMC's reported evaluation of Categories 1–4 and the additional Goals and Metrics from the Evaluation Design Table.

Key evaluation themes included:

- Process and outcome successes (Successes)
- Strengths
- Characteristics that facilitated success/lessons learned
- Process and outcome deficiencies (Areas for Improvement)
- Barriers to success
- Ability to spread/transfer successful processes
- Ability to sustain successes
- Other lessons learned
- Recommendations for future projects

Summary of Key Findings

Successes and Strengths

- Work with hospitals and other providers throughout the state over the five years increased connections and expanded relationships. Other statewide projects, such as APM, can be more easily implemented as a result.

- CMH set up 18 telehealth sites in clinics across Kansas, where Beacon patients received consultative services. While these appear to only be used currently for Beacon consultative visits, having the infrastructure in place could be beneficial for future projects.
- The Beacon practice achieved PCMH recognition in 2015 and re-recognition in 2018. One PCMH practice participant achieved NCQA PCMH recognition. Despite multiple barriers, two PCMH practice participants fully implemented all but one of the 25 PCMH competencies. The remaining practice fully implemented almost two-thirds of the competencies and had at least partially implemented all but one competency.
- Of the 242 provider organizations (hospitals, nursing facilities, emergency medical services and others) participating in some capacity with the STOP Sepsis program, 2308 individuals were trained. UKHS trained 250 SPARCC facilitators from 2015 through 2020, exceeding their goal of 90 within the first year. While a large amount of people trained did not facilitate patient workshops or formal training upon return to work, knowledge of SPARCC and STOP Sepsis increased throughout Kansas.
- The PCMH participating practices received incentive payments depending upon their level of project engagement (earned compensation points). Three of the four PCMH practices remained engaged throughout the project. The fourth practice's level of engagement slowed after obtaining PCMH recognition and ended upon sale of the practice.
- UKHS's staff and CMH's PCMH practice facilitators demonstrated adaptability and availability to respond to participating providers needs for different approaches to their programs, more intensive coaching and revision of resources (e.g training, data collection, and technical assistance).
- UKHS and CMH provided high quality educational materials, project resources, and web-based communication materials through a variety of media.
- UKHS leveraged the Kansas Health Care Collaborative's (previously called the Kansas Heart and Stroke Collaborative) existing provider network relationships and outreach activities to recruit DSRIP participants throughout the state.
- UKHS and CMH implemented various technology (UKHS – REDCap; CMH – data integration platform) to improve the amount and quality of data needed for program evaluation.
- CMH developed an infrastructure of telemedicine sites with providers around Kansas, for consultation purposes. With the COVID-19 public health emergency, CMH and UKHS increased use of telehealth for practice facilitation, patient workshops, and in-home patient visits.

Areas for improvement

- Measurement was a primary area for improvement.
  - Process and outcome measures often had non-matching measure titles, metric descriptions, numerators and denominators (more common with UKHS measures), and use of ambiguous words, leading to different interpretations of what was intended to be measured and frequent proposed metric revisions and clarifications.
  - Methods for measure calculations (inclusion/exclusion criteria, data sources, sampling methods, data reporting periods, etc.) were not specified prior to project implementation and not identified in the hospital's reports, often leading to interpretation and validity questions.
  - The ability to determine meaningful improvement was impacted by inconsistent identification of baselines, benchmarks/long term goals, and annual targets.
  - While CMH and UKHS both added some metrics, reported analysis typically had no additional analytics, such as stratification of the data by region or provider group to help with interpretation of the data and determining need for targeted improvement. Numerators and denominators were not consistently provided with reported percentages.

- There were data discrepancies in report narratives and spreadsheets, indicating incomplete data quality checks. Discrepancies were not always corrected.

- Project implementation and reporting were also areas for improvement.
  - Reporting often had insufficient detail to demonstrate how well plans were carried out. This happened less often with the PCMH project.
  - Reporting often did not address whether the data represented the target population (Medicaid and uninsured populations) or how much the interventions involved the targeted provider participants since reports indicated other populations and providers were included.
  - KFMC recommendations and follow-up questions were not consistently addressed, with some being repeated over multiple years.
  - Several goals and metrics were not addressed, primarily involving UKHS and the additional goals and objectives (not from Categories 1–4).

Barriers

- Sustained provider engagement is difficult for several reasons.
  - Limited financial and staff resources (due to travel budgets, time taken away from continued office/facility responsibilities, and staff turnover) limit provider participation in training and follow-through with post-training expectations.
  - Lack of physician/leadership long-term buy-in, and in some cases initial buy-in regarding the need for and benefits of participating in the project.

- Data is an ongoing issue impacting success of the projects.
  - Not having access to Medicaid data outside of the DSRIP hospitals' health systems, such as claims, encounters, or eligibility data, hindered the ability to determine eligible patients for goal setting, targeted outreach, and some process and outcome measures. Patient level data was generally not available unless it was patient self-reported, collected from medical records or electronic medical records (EMRs), or manually entered into a provided database. CMH received some MCO data infrequently and not from every MCO.
  - Participating providers often did not have staff available for data entry into project specific databases and many had compliance concerns regarding sharing data.
  - There were provider gaps in coding and billing practices to capture data for use with population health management.
  - DSRIP participants that did not have established electronic medical records with robust reporting and data mining capabilities was a barrier for the PCMH, SPARCC and STOP Sepsis projects. In some cases, practices were in the process of implementing their first EMR and others were either upgrading or changing EMRs. Even if a practice had an established EMR, their staff may not have known how to use it effectively.

- Consistent patient attendance at SPARCC workshops was a challenge, limiting the ability to fully evaluate the success of the workshop from week one to week four and week one to the six-month follow-up.

- After DSRIP started, in 2016, Children's Mercy's legal counsel evaluated related regulatory issues regarding the Beacon project. After multiple months, it was determined contracts would be required for primary care practices in Kansas. Beacon noted, *the contracting process was initially a substantial barrier, taking multiple months (6-8) to be signed.* A Children's Mercy "regulatory

group" also determined after the Beacon program began that the planned in-home telehealth visits would not be allowed since there was no code to use for billing these services. The changes in approved billing for telehealth during the COVID-19 public health emergency lifted this barrier.

Lessons Learned

- UKHS learned they needed to provide more explicit explanations of expectations for project participants up front, and gain leadership buy-in during recruitment. They needed to target people with the authority to make decisions while carrying out the project implementation, and with the capacity to conduct the project activities. Once recruited and trained, community facilitators needed more one-on-one guidance and follow-up than first anticipated.
- Providers often have too many competing priorities to allow for sustained participation (e.g., implementation of EMRs, practice being sold or physicians planning retirement, participation in other QI or value-based projects requiring data submissions).
- Shorter educational sessions were needed, shorter videos, and taking the training to the participating partners limiting their travel time and expenses.
- For the SPARCC project, UKHS discovered that participating organizations, especially those also in the Kansas Health Care Collaborative, were some of their best advocates. Because they are peers with prospective participants, they have credibility.
- After many outreach and recruitment efforts, the Beacon program concluded many community providers did not feel the need or desire to partner with them for ongoing consultation regarding their child patients with medically complex needs.
- It is important to consider who can benefit from the program the most when determining parameters for recruitment (e.g., newly diagnosed or in early stages of heart failure).

Summary of Key Recommendations

1. Hospitals should evaluate the feasibility of interventions and metrics more closely before their plans are submitted. Provide rationale for estimates of provider participants and patient population sizes to help ensure projects/interventions have sufficient numbers involved. Prior to proposing interventions, ensure the needed data is available and hospital legal counsel has been consulted, if needed.
2. Ensure process and outcome measures are well-written and will measure what is intended. Develop technical specifications for measure calculations (inclusion/exclusion criteria, data sources, sampling methods, data reporting periods, etc.).
3. Additional time should be requested to address any EQRO and State staff concerns and recommendations. Revisions should be completed before final approval. Metrics should be revised, as needed, with quick feedback and approval from CMS. In a multi-year project, metrics should be reviewed and revised as needed to better assess project progress.
4. MCOs and the State should assist with access to Medicaid data for identifying populations and calculating claims-based rates when the data is not available to the DSRIP hospital. If data is not available from the MCOs or State, the hospitals should explore alternative methods to obtain data to evaluate program effectiveness (e.g., collaborative service agreements for data sharing).
5. Calculate baselines using a time period prior to the start of the intervention. Have rationale for selecting short and long term goals (e.g., benchmarks, scientific literature). Consider tracking and trending over time when evaluating success. Ensure the hospitals and State have similarly

prioritized goals and agreed upon scope of activities (e.g., amount and type of NF education resource development) and that they are conducted accordingly.
6. Require an analytic plan, including report format, prior to conducting analysis and obtain State approval. Consider using the CMS EQR Protocols' Performance Improvement Project report template.
7. Develop an agreed upon report format and a method for hospitals to ensure they address, or provide rationale for not addressing, all recommendations.
8. Ensure the hospitals implement all previously planned activities or obtain approval to eliminate the activity.
9. Improve reporting: Increase clarity and provide enough detail to demonstrate progress and explain variation in project implementation and data. Improve data quality checks and ensure reporting of data in narrative, figures, and tables match.

Evaluation Findings by Project Phase

Pre-DSRIP Implementation **Program Planning** (including development of metric specifications, application templates, and reporting templates) and **Project Proposal Approval Processes**.

Pre-DSRIP planning began in February 2013, with development of draft protocols by May 2013 and hospital initial proposals submitted in May 2013. A metrics catalog (drafted in July 2014) included a broad scope of potential metrics by category from which the hospitals could choose. The metrics included measure count, measure name, metric, National Quality Forum (NQF) number, measure steward, and data source. They primarily were metric titles and descriptions, with measure source. Numerators, denominators and anticipated target levels were not identified until the hospitals' proposals were developed. The hospitals completed development of their proposals, which were sent to CMS September 30, 2014. The timing for the hospitals' submissions of the first and second drafts of their proposals did not allow enough time for the hospitals to develop the drafts and for iterations of review, feedback and revisions to occur between the Sate, EQRO and hospitals. This resulted in EQRO recommended revisions to proposed metrics not being incorporated into the proposal. Metrics were problematic throughout the implementation, reporting and evaluation of the DSRIP program.

Recommendation

Additional time should be taken to review and address EQRO recommendations and/or concerns before metrics are finalized.

Category 1 **Infrastructure milestones** – laying the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.

Successes and Strengths

- Work with hospitals and other providers throughout the state over the five years increased connections and expanded relationships. Other statewide projects, such as APM, can be more easily implemented as a result.
- UKHS staff has capacity to serve as workshop facilitators and to complete data collection.

- UKHS's network of hospitals and physician practices across Kansas expanded over the past five years due to the Kansas Health Care Collaborative (previously called Heart and Stroke Collaborative), which helped further expand DSRIP project implementation.
- UKHS's training was provided throughout Kansas; methods were altered to reach more people.
- UKHS responded to partner feedback and identified barriers with alternatives, such as providing more detailed assistance with data collection, including entering the data themselves.
- UKHS sought ways to increase user-friendliness and quality of data entry and clinical practice (e.g., REDCap, and Redivus).
- The CMH Beacon obtained PCMH Level III recognition in December 2015, and re-recognition in early 2018.
- CMH has robust documentation systems, including care plans and order sets; they routinely implemented improvements, including switching from PowerNote to DynDoc in 2020.
- The reports "PCMH Engagement Model Scores" and the "Competency Checklist" were effective tools for evaluation of PCMH participating practices. The PCMH Engagement Model Score identified practice participants' earned compensation points used for determining the level of incentive payment the practice receives.
- There was general continuity of the CMH team and the PCMH practice level teams.

Areas for improvement

- The STOP Sepsis project was supposed to focus primarily on nursing facilities but instead focused on hospitals (where KU was already providing sepsis training).
- Baseline data weren't collected (as they were supposed to do) on nursing facility sepsis cases to allow comparison. Part of the reason was not enough NF staff capacity (and limited effort from UKHS).
- Data quality checks and validation of data transfers into new databases were incomplete.
- Report improvement was needed
    - Reporting often did not address whether the data represented the target population. Given that people diagnosed with heart failure are more likely to be of Medicare age, UKHS did not address how many of the patients in the SPARCC education sessions had Medicaid or were uninsured. UKHS Case Reviews were initially reported to be monthly STOP Sepsis case reviews and later clarified to include multiple topics open to broader provider populations and not just those targeted for the STOP Sepsis project. CMH Beacon included information regarding Missouri a couple of times, and upon KFMC questioning, PCMH staff clarified data discrepancies were because one measure included military patients' information.
    - The level of detail provided did not always demonstrate progress or clearly describe what occurred.
    - There was inconsistent reporting of cumulative and individual data.
    - There were often data discrepancies.
    - Redundant reporting occurred among report sections.
    - Calculate measures correctly. In one case the Total Numerator presented included targeted and non-targeted participating providers, and the Total Denominator included only the targeted number of providers, appearing to indicate substantially more of the targeted providers were reached.

Barriers

- After the DSRIP metrics were approved, CMS reporting requirements expanded for NFs. Staff that might have been available to report data for DSRIP had to focus on data they were needing to start reporting to CMS.
- There were no data available to UKHS to identify the total number of heart failure patients (not just those with hospital admissions) in the state or by region, for purposes of identifying denominators and setting targets.
- The release of new NCQA PCMH standards and delayed availability of application submission processes impacted the PCMH practices in the middle of the project time-period.
- Provider participant related barriers included:
  - Not having the experience, technical capabilities or administrative bandwith to collect data.
  - Many partners have been reluctant to share data due to compliance concerns.
  - Partners are reluctant to participate in any initiative that requires data collection and reporting.
  - Health Information Technology limitations.
  - Limited resources, limited staff and travel budgets.
  - Lack of physician participation.
  - Lack of long-term buy-in.
  - There is staff turnover and not enough time to train new staff members.
  - Staff are uncomfortable providing data to UKHS.
  - The facility had already implemented sepsis protocols and did not need to report information to UKHS.
  - The benefits of participating in data extraction are unclear.
  - Difficulty in sustaining community facilitators to actively offer workshop.
  - Most nursing facilities (NFs) do not use electronic health records.

Lessons Learned

- Needed to provide more explicit explanations of expectations relating to participants dissemination of education on sepsis to other staff, modeling protocol driven approaches to sepsis recognition and treatment, designing and implementing a QI program on sepsis, and reporting data on a continuing basis.
- Did not originally target top hospital leaders for buy-in during recruitment efforts.
- Upon follow-up with participants, it became apparent that many staff attending the STOP Sepsis program from hospitals had little ability to implement the education or QI initiatives in their organizations. Many had signed up for the program through permission of their immediate superiors, but rarely were top decision-makers involved.
- It is necessary to build critical capacity within partner organizations to carry through with the project.
- Providing training where participants do not have to travel is important.
- Overcoming the structural and attitudinal barriers is not only critical to the success of the project, but these organizations' ability to meaningfully participate in value-based payment programs.
- Participating practices often have too many competing priorities (e.g., implementation of EMRs, practice being sold, physicians planning retirement, new CMS reporting requirements for NFs).
- Impact of COVID-19 public health emergency diverted resources, changed health care utilization, and expanded capabilities for telehealth.

Recommendations

Metrics and Data

- Define up front the terms used in the metrics, such as "identified," "potential," "fully engaged," "interested."
- Develop clear and complete technical specifications for metrics up front.
  Ensure Measure name, metric, numerator and denominator are in alignment and represent what was intended to be measured. Additional time should be requested to address any EQRO and State staff concerns and recommendations. Revisions should be completed before final approval. Metrics should be revised, as needed, with quick feedback and approval from CMS. In a multi-year project, metrics should be reviewed and revised as needed to better assess project progress.
- Evaluate feasibility of metrics more closely before the plan is submitted.
- With future projects, assess how to address potential partners' compliance concerns regarding data release (e.g., messaging to providers State and Federal support of the project, and review compliance processes regarding data release).
- Consider metrics, provider and patient inclusion as well as goal targets more thoroughly to reduce revisions.
- Review and condense overlapping metrics.
- Ensure the ability to modify metrics and goals to address changes to standards or practices outside of the hospital's control.
- For evaluation regarding the effectiveness of the training and whether objectives were met, complete a short pre- and post-training survey/assessment.
- Develop analytic plan, reporting format, technical specifications early in the process; obtain State and EQRO feedback prior to implementation.

Goal setting and benchmarks

- Set goals up-front for participation over the project period (and by region if applicable).
- Include targets and set timelines (e.g., all identified community partners trained in the first year, or 50% in first year, 50% second year, etc.). Allow modification of goals and metrics as lessons are learned (and as changes occur over time in technology and reporting requirements that could impact measures and metrics).
- Set improvement goals at the beginning of the project, assess whether annual 10% improvement is appropriate. Review literature for potential benchmarks, rather than setting the goal after being years into the project and having already reached the goal.

Hospital Reporting

- Focus reporting on the specific functional metric and discuss the related process and outcome metrics in those related sections, reducing redundant reporting among sections.
- Report data and information specific to the targeted populations and if other populations are added to the project, report them separately. The hospitals and the State should evaluate whether they are meeting the needs of the target population.
- Hospitals should complete data quality checks on a periodic basis and complete validation when transferring from one database to another.
- Quantify assessments of reasons partners may not fully participate while developing project proposals and periodically during the project.
- The hospitals should more clearly address what processes and tools are already in place.
- Increase clarity and provide enough detail to demonstrate progress; only report performance in Kansas.

- Provide cumulative and individual data, and conduct data quality checks to reduce discrepancies.

Category 2: Process milestones – process changes and improvements.

Successes and Strengths

- CMH set up 18 telehealth sites in clinics across Kansas, where Beacon patients received consultative services. While these appear to only be used currently for Beacon consultative visits, having the infrastructure in place could be beneficial for future projects.
- The Beacon practice achieved PCMH recognition in 2015 and re-recognition in 2018. One PCMH practice participant achieved NCQA PCMH recognition. Despite multiple barriers, two PCMH practice participants fully implemented all but one of the 25 PCMH competencies. The remaining practice fully implemented 16/25 (64%) of the competencies and had at least partially implemented all but one competency.

Training and education

- UKHS trained 250 SPARCC facilitators from 2015 through 2020, exceeding their goal of 90 within the first year.
- UKHS's demonstrated adaptability and availability to respond to facilitators needs with more intensive coaching and revision of the training resources (e.g., reducing the workshop's length and emphasizing facilitation skills over clinical content).
- CMH PCMH Practice Facilitators were flexible and able to respond to the PCMH practice participants' needs (e.g., implementing and changing electronic medical record systems) and changes to the NCQA PCMH standards in the middle of the DSRIP project.
- UKHS and CMH demonstrated the ability to provide high quality educational materials, project resources, and web-based communication materials through a variety of media.
- Beacon developed guides by individual county statewide on a wide variety of resources available in their county. Although the guides were developed to assist families with children with complex health needs, much of the information in the resource guides are applicable to other families as well.
- Of the 242 provider organizations (hospitals, nursing facilities, emergency medical services and others) participating in some capacity with the STOP Sepsis program, 2308 individuals were trained.
- In 2016, UKHS identified few of those trained were completing patient education groups. With attendee feedback, UKHS revised its recruitment strategy by targeting facilities (rather than inviting individuals) and securing attendees' up-front commitments to local program implementation.

DSRIP hospital staff capacity and engagement

- Through the UKHS partnership with the Kansas Health Care Collaborative (previously called the Kansas Heart and Stroke Collaborative), health coaches around the state were trained and assisted with SPARCC patient education groups. The sustainability of this approach is not clear.
- UKHS also leveraged the Health Care Collaborative's existing provider network relationships and outreach activities to recruit DSRIP participants throughout the state.
- UKHS provides templated materials to facilitators and partner organizations to aid in patient recruitment such as "prescription" pads for providers to prescribe SPARCC and templated letters and emails.
- The Beacon program developed collaborative services agreements (CSAs) and co-management guidelines within the CMH system, and the PCMH program facilitated the development of CSA between the PCMH practice participants and community specialists.

- CMH developed additional project management tools, such as a "PCMH competency checklist" to more clearly guide and track completion of required elements.
- UKHS and CMH were willing to add supplemental measures to more effectively evaluate the program. For example, UKHS added a measure to focus on increasing the number of trained facilitators who completed a patient education group, rather than only the number trained.
- UKHS identified and documented lessons learned and subsequent revisions throughout the DSRIP years.

Use of technology

- UKHS implemented the use of REDCap for participant organization's direct data entry, additional analysis and reporting capacity and for improved feedback during individual facility/provider visits. For example, they were able to review individual patient cases to identified targeted opportunities for improvement, as well as to look for more global patterns.
- UKHS collaborated with Redivus, to develop a sepsis protocol application for provider use.
- UKHS has the capacity and technical resources to develop effective virtual tools.
- CMH developed an integrated data platform for use by the PCMH practice participants.
- With the COVID-19 public health emergency, CMH and UKHS increased the use of telehealth for practice facilitation, patient workshops, and patient visits.

Lessons Learned

- Shorter educational sessions were needed, with more emphasis on facilitation skills than clinical content.
- Recruited and trained community facilitators were not experienced in this type of initiative and needed more one-on-one guidance and follow-up than first anticipated.
- It is critical to obtain buy-in from decision-makers at each healthcare facility participating in the program.
- For the SPARCC project, UKHS discovered that participating organizations, especially those also in Kansas Health Care Collaborative, were some of their best advocates. Because they are peers with prospective participants, they have credibility.
- UKHS noted, recruitment of heart failure patients and supporters by facilitators to group sessions has been more difficult than expected. These patients often can be very ill, making attendance at all sessions difficult. Because of this, the SPARCC team now recommends that facilitators target newly-diagnosed HF patients as well as those with fewer co-morbidities.
- The SPARCC team now appreciates that facilitators lack experience with this type of initiative and therefore they do not understand the need for broad communication about the training within their organization and throughout their communities. The SPARCC team included a more extensive discussion of recruitment during the workshops. Also, team members addressed recruitment in their first post-training meeting and circled back during every subsequent contact. Examples of contacts the team recommended newly-trained facilitators make: presentations at medical staff meetings; discussions with the respiratory therapy department and discharge planners; and meetings with area agencies on aging, local pharmacies, local durable medical equipment companies, churches, home care agencies, and senior centers.
- UKHS learned it was more effective for the SPARCC team member to attend every group session to assist with paperwork completion and data collection. After the conclusion of the initial session and the "booster" the SPARCC team conducted a 'debrief' with facilitators to aid continuous improvement.

- The Beacon program learned many community providers did not feel the need or desire to partner with Beacon for ongoing consultation regarding their child patients with medically complex needs.

Barriers

- It can be challenging for trained facilitators to devote the time needed to conduct trainings as often as may be desired.
- Community facilitators lacked time to complete and review paperwork.
- Consistent patient attendance at the SPARCC workshops was a challenge.
- NFs were difficult to recruit for case review participation. UKHS suspected the barrier was feeling uncomfortable joining cross-setting case reviews (this wasn't verified).
- Due to workload of the PCMH practice participants' clinics, sometimes they state that they want to start working on something, but then changes in staff, illnesses, or just day-to-day patient care affects their progress.
- Changes to the NCQA PCMH standards in the middle of DSRIP and glitches in the NCQA application system/process.
- Once the one PCMH practice participant achieved their NCQA PCMH recognition, they were no longer invested as a collaborative participant. This in part was due to staffing changes and a new clinic infrastructure. The same practice was later sold and removed themselves from the DSRIP project.
- DSRIP participants that did not have established electronic medical records with robust reporting and data mining capabilities was a barrier for the PCMH, SPARCC and STOP Sepsis projects. In some cases, practices were in the process of implementing their first EMR and others were either upgrading or changing EMRs. Even if a practice or facility had an established EMR, their staff may not have known how to use it effectively.
- No-show rates for sessions following the initial meeting creates challenges in evaluating the program's impact, as outcomes may vary by the number of sessions a patient was able to attend.

Areas for improvement

- Frequently there was inconsistent reporting by the DSRIP hospitals, with data discrepancies and insufficient detail to demonstrate whether plans were carried out.
- The measure titles, metric descriptions, numerators and denominators frequently did not match, particularly among the UKHS metrics.
- Identification of benchmarks, goal setting and annual targets were inconsistent, sometimes not identified, or appropriately updated.
- Planning and conducting evaluations of provider and patient participant satisfaction with the DSRIP hospitals was generally limited.
- Implementation of learning collaboratives was varied among the projects. It appears the collaborative case reviews for STOP Sepsis were not conducted as originally indicated (monthly). UKHS reported in 2019 the case reviews were for the larger "Care Collaborative" participants and covered a range of topics. The PCMH practice participants were prompted to respond to CMH questions on the online Message Board after Learning Collaborative webinars.
- Since participants should attend all four sessions for the intervention to be effective, further information regarding consistency of attendance is warranted to evaluate the success of the program.
- KFMC recommendations and follow-up questions were not consistently addressed, with some being repeated over multiple years.
- Some initial goals and objectives were never addressed, including:

- A specific marketing plan for education to the general public about sepsis by UKHS
- Development of Beacon collaborative service agreements with non-CMH specialists
- Data collection for identification of STOP Sepsis provider participant baselines.

Recommendations

Project proposals

- Ensure the measure title, metric description, and numerator/denominator align and measure what is intended.
- Require development of technical specifications for measures, including verifying data availability and definition of terms (e.g., "trainer" versus a "facilitator").
- Identify feasible data sources and assist the hospitals in accessing the data or in providing them information to identify eligibility and targeted patient populations for denominators and goals.
- When developing interventions and process measures, identify specific methods for evaluation and determine feasibility (e.g., electronic tracking of people accessing resources, surveys, etc).
- Ensure the hospitals and State have similarly prioritized goals and agreed upon scope of activities (e.g., amount and type of NF education resource development) and conducted accordingly.
- Allow enough time for this level of review and revisions.
- Require development of an initial analytic plan:
  - If an intervention intends for a certain number of sessions to be attended, the analysis should include descriptive statistics identifying the number of sessions patients attend, even though the official metric may be based on attending one session. Consider a measure identifying the number of patients that completed all sessions in the program.
  - Data should be compared to like time periods; include annual comparisons.
  - Report data by region, if the goal is to have a certain number of facilitators by region, and by state.
- Require hospitals to clearly identify in the project proposal what activities are already completed prior to the project implementation, and what overlap occurs between existing partnerships and program participants.

Project implementation

- Develop an agreed upon report format.
- Develop a recommendation tracking tool for the hospitals to document how they addressed each recommendation or their rationale for not implementing the recommendation. This would allow the State to more readily track areas for improvement and would foster discussions regarding State expectations.
- Reporting needs to be clearer (e.g., description of the Learning Collaborative case reviews and that they were not all specific to sepsis, reasons for changes in the data).
- Need to follow-through on planned frequency of activities (eg., learning collaboratives).
- The hospitals should conduct data validation and review reported data for errors. For instance, ensure data completely transferred to new data systems (e.g., migration to REDCap).
- With future projects, provide the State (and EQRO if applicable) copies of outreach and training materials for review early in the project.

Category 3: Quality and outcomes milestones – Metrics associated with these milestones address the impact of the project on quality metrics and beneficiary outcomes.

Strengths

- UKHS implemented a process for more accurate data collection through REDCap.
- UKHS devoted necessary resources to abstract medical records from over 20 hospitals that did not directly enter their own data into REDCap.
- In 2018, UKHS reported, following completion of chart review at each facility, UKHS staff meets with the facility's staff to review performance, reviewing individual cases and specific opportunities for improvement. Staff also discuss how the hospital is performing relative to its peers.
- The UKHS STOP Sepsis program followed the national Surviving Sepsis Campaign's standards of practice, conveying changes to the STOP Sepsis hospitals.
- CMH evaluated and reported the reasons individual patients did not meet the Beacon Category 3 measures.
- The PCMH practices improved most of the Category 3 metrics over the course of the project.
- CMH implemented a data integration platform that assists the practices in accessing more complete data.
- CMH recalculated rates from the previous year, excluding the one PCMH practice that left the program, to allow for an annual comparison of rates going forward only involving the three practices.

Areas for Improvement

- Measure titles, metric descriptions and numerators/denominators were not in alignment; it was unclear what was intended to be measured. Almost all UKHS measures had clarifications and proposed revisions once the projects began.
- Comparisons were made in measures using different inclusion time periods, and in measures tracking patient improvement over time reflecting different patients. For instance, comparisons should not be made between a group of workshop participants in the SPARCC workshop week 1 and a different mix of patients in week 4.
- Comparisons couldn't be made year to year where it wasn't clear which hospitals, which types of hospitals, and sizes of hospitals were included in the data reported.
- There were data discrepancies in report narratives and spreadsheets.
- Recommendations were not consistently addressed.
- UKHS did not report or explain changes in previously reported rates or obtain approval for a revised baseline.
- Appropriate measure changes, based on changes to nationally recognized standards of practice, were unable to be approved in a timely manner.
- The metric does not determine improvement in care due to ambiguity (i.e., increase in transfers for severe sepsis).

Barriers

Measurement Data

- Difficulty identifying eligible patients for goal setting and targeting outreach.
- Reliance only on self-reports from patients who happen to be attending a session, and no access to EMR or claims data.
- Differences in timing of data collection resulting in aggregated data including data from different time periods. For instance, STOP Sepsis data from the largest contributors were entered consistently because they enter their own data directly into REDCap. However, data from other hospitals were completed by a UKHS data abstractor who traveled to other facilities approximately quarterly. UKHS

worked with partners to have more of them enter their own data into REDCap but staffing at their partner organizations was a major barrier.

- UKHS's didn't discuss differences in the composition of hospitals included in the aggregate STOP Sepsis data each year, or differences in sepsis identification by type and size of hospital. Was it one or two big hospitals with the big errors in dx? Was it mostly little hospitals? Was it in urban areas or was it in rural? Of 100 hospitals reported in one year, how many of these were in the next year's data?
- The sepsis protocols changed mid-DSRIP and no longer really matched the original metrics. was obligated to continue reporting approved STOP Sepsis metrics for payment purposes, when they would have been more appropriately eliminated due to a change in the standards of practice. Another STOP Sepsis metric continued to be reported even though it was determined to not be meaningful due to potential for different interpretations (ie., increase in transfers for severe sepsis or septic shock).
- For the PCMH project, CMH experienced data challenges in identifying patients/members who have Kansas Medicaid and gaining access to claims to determine baseline and quarterly progress. They received data from the Kansas MCOs infrequently, and in some cases not from every MCO, which made it more difficult to develop gaps in care reports for the practices.
- The CMH PCMH staff reported the majority of data discrepancies in denominators for three measures with the same population were because vaccine information was also entered for non-Medicaid (children from military families) into WebIZ. It was not clear why the populations couldn't be identified separately when pulling the data.
- The facilitators have also found gaps in billing practices to capture HEDIS, so much education and work continued to reinforce best practices with coding and billing which will enhance population health management and capturing the work the providers complete (e.g., Weight Management counseling).

Patient-Related

- There were too few children (ranging from two to eight each year) in Beacon measures for specific age groups to allow valid annual comparisons of progress for this metric. KFMC repeatedly recommended CMH include all Kansas children who meet the age criteria (age 2 for this metric) who received Beacon services during the reporting period, including Beacon HOMES siblings, Beacon siblings, and Beacon consults. While the numbers would have still been small, all children served through Beacon would have been assessed for the measure with results reported. CMH was inconsistent with this.
- CMH identified the barrier of having children start receiving services from Beacon who are missing immunizations for which it is impossible to become "caught up" (examples: 2 Rotavirus immunizations are to be administered on or before 8 months of age; if the child age 2 has not received flu shots to date, 2 flu shots would not be administered at age).
- UKHS reported the following patient-related barriers regarding SPARCC workshops:
  - Patient attrition.
  - Patients attending a class once a week is either not feasible or not desirable. Therefore, they miss sessions, sometimes including the first session at which baseline data are collected.
  - Winter weather for sessions later in the year.

Lessons Learned

- In communicating with facilitators, UKHS discovered that some facilitators are so eager to get started on their patient groups that they do not carefully select the participants.

- UKHS noted because the SPARCC program is designed to be preventive it is not necessarily appropriate for patients in the later stages of heart failure. It appears some patients recruited for the program during DY4 were "too sick" to benefit from the program. However, they did not address what "too sick" meant and why they and their families couldn't benefit from learning stress relieving skills.
- Those who can benefit the most are those newly-diagnosed with heart failure or at least still in the early stages of the disease.

Recommendations

Data

- MCOs and the State should assist with access to Medicaid data for identifying populations and calculating claims-based rates when the data are not available to the DSRIP hospital. Explore methods to obtain data other than patient self-report to evaluate program effectiveness.
- Ensure final Project Plans include all CMS and State changes after review of the draft Plans.
- Develop a timely process for approving project and measurement revisions when standards of practice change (e.g., Immunization Combination 2 vs. Combination 10, STOP Sepsis protocol change)
- Metrics
  - The hospitals should thoroughly review the metrics for clinical appropriateness and feasibility of data collection. Propose revisions prior to the project beginning.
  - Allow changes in the metrics where metrics are later determined to not be appropriate for assessing progress for a measure or where changes in technology or major federal or state reporting or programs are instituted (PCMH, NF reporting requirements, sepsis protocol changes, etc.).
  - With future projects, ensure the measure represents the people targeted for participation in the program (e.g., hospital readmission measure when targeted workshop participants may not have previously been admitted).
  - Consider the hypothesis and goals of the proposed program or intervention when determining remeasurement time periods (e.g., assessing readmissions six months after workshop, rather than weekly during the workshop).
  - Define ambiguous terms in metrics (e.g., timely manner, engaged, interested) and provide specifications for how data are collected to determine timely care.
  - Review proposed targets for meaningful improvement specific to the metric. For instance, is 50% target adequate for all years of the project, regardless of whether rates increase or decrease? It may or may not be depending on the clinical implications. Track and trend data over time, rather than only setting targets based on the previous year's rates, as a rate with 10% improvement from the last year may still be much lower than baseline.
- Require detailed technical specifications, data collection tools and report formats to be submitted prior to beginning data collection and reporting.
  - Require technical specifications for each measure, including data source, inclusion time periods, diagnoses and procedure codes, and calculation steps.
  - Identify inclusion/exclusion requirements, including the enrollment criteria (e.g., "active" at year end, continuous eligibility criteria, at any point in time, etc.).
  - Specific methodologies should be submitted when surveys are part of the project, including number to be surveyed, use of different survey modalities and planned efforts to follow-up with patients/families after initial non-response.

- Develop an analytic plan and report format early in the project to get input from the State and EQRO regarding certain aspects, including:
  - Approach to comparisons. For interventions that intend to have the patient attend a certain number of sessions, compare results in final week with week 1 only for those who reported data in both week 1 and the final week, and for remeasurement several months later, compare results at the remeasurement month for only those who participated and reported data in week 1 and the identified remeasurement month.
  - Track performance over time by facility or type of facility and report specific trends or comparisons, such as the seemingly disproportionate number of sepsis and severe sepsis cases among the hospitals in the measure compared to those that did not have 12+ months with the project.
  - Determine appropriate aggregation of sub-populations to increase denominators (e.g., Kansas Beacon HOMES siblings, Beacon siblings, and Beacon consults.
  - Report data by de-identified hospital to allow tracking of individual improvement and hospital comparisons to its peers. This would address data collection/submission time period differences between hospitals, and types, sizes, and locations of hospitals. Annual comparisons should be completed using the same inclusion time periods
  - Determine how to handle semi-annual and annual measurements when data spans time periods (workshop Week 1 and Week 4 comparisons are in one reporting period and the six-month follow-up results are in a later reporting period).
  - Determine how to incorporate data lags in reporting, so data from the same time periods are included in each report without having to change previously reported rates when data are refreshed or data abstraction is completed.
  - Additional information as to the types and sizes of facilities included in the analysis would be helpful to include in the summary analysis. (e.g., How many of the 23 facilities were nursing facilities? How many of the facilities were from community hospitals? Were there differences in rates of missed diagnosis at different categories of facilities?)
  - Annual comparisons should be conducted using the same measure; when measure calculations are revised (e.g., different time periods, different populations etc.) previous data should be revised to allow for comparisons.
  - Comparisons should not be made between the current annual rate (2018) and the previous year's revised annual rate (2017, revision reported in 2018) due to differences in completeness of data.
  - Ensure methods are developed to obtain baseline data prior to intervention. Baselines should be determined from valid data sources, and goals should be evidence-based (standard benchmarks, literature review).

Implementation and Reporting

- Project reports need to provide detail regarding data collection and measure calculations to be able to verify accuracy and understand data discrepancies during evaluation.
- Reduce redundant reporting in metrics across Categories 1–4.
- Hospitals should conduct periodic data entry quality checks and validate data in a new database to ensure accurate transfer from a previous database.
- If a baseline rate, long-term goal or the agreed upon method for determining the annual target rate changes, discuss and obtain approval from the State.
- Denominators should be the same numbers when the denominator description is the same; if not, explain why and explore methods to identify the same population.

- Hospitals should evaluate cases not meeting numerator criteria to validate the measure and gain more lessons learned. This may include medical record abstraction on a sample of cases.
- PDSA cycles should be conducted in the improvement process, rather than stopping an evaluation at identifying reasons patients did not obtain the care (e.g., flu shot, Health & Services assessment/plan, Emergency Information Form). Describe specifics regarding ongoing monitoring and what steps will be taken towards improving rates.
- Hospitals should improve reporting.
  - Consistently provide numerator/denominator with percentages.
  - When reporting a "significant" finding, it should indicate statistical significance testing occurred; provide a p-value to strengthen the finding.
  - Provide explanations of wide variations in rates/number, and reasons for changes in previous data.
  - Create static copies of results to avoid having previously reported data change over time.
  - Address any changes in previously reported rates and obtain approval for baseline rate and goal changes.
  - Correct previous data discrepancies, documenting the reason for the change.
  - Reporting of data in narrative, figures, tables etc., should match.
  - Labels in figures and tables should clearly specify the data being reported.
  - With measures that involve performance of different partners, the annual reports should provide additional details (such as facility type, size, urban/rural location, and available baseline data) to allow a more valid comparison of annual rates.

Category 4: Population focused improvement milestones – Metrics associated with the broader impact of the selected projects.

Most UKHS Category 4 metrics improved, except Metric 4.3 (Improve rate of adults 18–85 years of age diagnosed as hypertensive whose blood pressure is adequately controlled). UKHS relied on existing data provided by the State, MCO or EQRO for Category 4. Metric 4.1b. (Number of frequent users of ED) was never provided by UKHS since it wasn't a measure already reported elsewhere.

KFMC was unable to determine the impact the DSRIP projects had on these rates. Kansas has numerous related projects through other organizations, including the Medicaid managed care organizations, other insurers, provider associations, state and local public health, and health care foundations. In 2019, UKHS reported 344 patients attended at least one week and 250 patients attended all four weeks of the SPARCC program; it wasn't reported how many caretakers attended the sessions. UKHS trained 2,308 health care workers in the STOP Sepsis protocols. Two of the UKHS Category 4 metrics were not addressed in the STOP Sepsis and SPARCC projects (i.e., rate of tobacco use screening and cessation intervention, and rate of adults diagnosed as hypertensive whose blood pressure is adequately controlled). Metric 3.4 of the SPARCC included blood pressure readings in the metric description. However, UKHS did not include blood pressure tracking in the patient self-reports because it wasn't in the measure title or numerator; they thought it was an error.

All CMH Category 4 metrics improved. These metrics were primarily based on performance of the CMH health system, of which the Beacon program would have had the potential for an impact. The number of patients Beacon served ranged from 38 (2015) to 168 (2020). It was not reported how many total unique patients were served over this time period. The Kansas Medicaid population served by the three PCMH clinics was approximately 3502 patients. When the project had the four PCMH clinics, the number of

Kansas Medicaid patients was around 4600. CMH relied on data from the KanCare MCOs for Measure 4.4 (Appropriate Testing for Children with Pharyngitis) and only one MCO provided data. Most CMH Category 4 metrics were also measured in the PCMH program.

Recommendations

- Ensure all metrics have technical specifications for calculation methods.
- Arrange for access to specific required data sources and determine who will calculate the metrics, if needed.

Evaluation Design Table Goals and Metrics

Since the goals and metrics in this section are related to the metrics in Categories 1–4, the following will focus on items not previously discussed. There were a number of redundancies in what the hospitals reported among the Categories 1–4 and the Evaluation Design Table Goals and Metrics. Also, within the reporting regarding the Evaluation Design Table Goals and Metrics, there was repeated content.

Areas for Improvement

- Several of the STOP Sepsis metrics did not appear to be fully addressed, including:
  - Training of family members of NF residents (part of Metric 2). While a large amount of provider staff members were trained, UKHS discovered they often did not realize they were expected to spread the information to others in their organizations. It was unclear what the process was for subsequent training of family members on the signs and symptoms of sepsis.
  - While UKHS increased provider awareness of sepsis identification, it did not appear a broader campaign occurred throughout the state to increase the general public's awareness (Metric 13).
  - Regarding Metric 3, UKHS indicated their training has a component specific to patient transfer, which is applicable to EMS providers and they note a total of 48 EMS providers have been engaged in the project. It is unknown how many have taken the EMS-specific training. None of the measures in Categories 1–3 addressed EMS providers' levels of improvement in knowledge or practice regarding sepsis identification.
  - Metrics 17 and 18 pertain to data collection and calculation of hospital and NF baseline rates by conducting a chart review of 60 records or of a six-month period prior to implementation of the intervention. The chart review was not conducted, and baselines were not established prior to the intervention starting. UKHS had indicated this was not feasible for the facilities.
- Goal 3 of the SPARCC program used an unclear term "train-the-trainer." UKHS trained facilitators. The original intention may have been to eventually train facilitators to be able to train other facilitators, but that was not addressed.

Barriers

- Goal 1 of the Beacon project was to implement and expand the Children's Mercy outpatient primary care center (the Beacon program) to provide regional comprehensive care coordination for Kansas Children with Medical Complexity. After DSRIP started, in 2016, Children's Mercy's legal counsel evaluated related regulatory issues. After multiple months, it was determined contracts would be required for primary care practices in Kansas. Beacon noted, *the contracting process was initially a substantial barrier, taking multiple months (6-8) to be signed.*
- Goal 6: Children who currently cannot travel to the Beacon Program clinic due to severe health care issues will have home visits with the goal of expanding these services further with telehealth visits.

In 2016, the Children's Mercy "regulatory group" determined these visits would not be allowed since there was no code to use for billing these services. With the COVID-19 public health emergency, and telehealth expansion, Beacon now uses that technology.

- Beacon noted they encountered resistance to their services, with providers indicating they can meet their Kansas patients' needs with services available elsewhere.
- Beacon staff also reported they may have overestimated the number of children in remote Kansas areas in need of Beacon services.

Recommendations

- Determine feasibility of the activities in these additional goals and metrics before final approval of the metrics.
- Fully address all goals and metrics, and implement all planned activities.
- Reduce duplication of metrics and reporting redundancies.
- Consider goals of the program when determining metrics for evaluating the success of the planned activities (e.g., success of the EMS training either through pre and post-survey, or other measurement).
- Hospitals should have legal and regulatory review at the time of developing the proposed project interventions, to avoid delays or cancelations of planned interventions after the program begins.
- Determine methods to assess provider and patient level of desire and/or need before planning the program or a specific intervention.