

The evaluation tool has the following sections:

1. Project Description section
  - a. *The Challenges* – Copy and paste these from the project narrative. In some cases, consider editing the wording to make it more concise and clear.
  - b. *The Objectives* – Copy and paste these from the project narrative. In some cases, consider editing the wording to make it more concise and clear.
  - c. *Target Population* – Copy and paste these from the project narrative.
  
2. Alignment section
  - a. *Community Needs Addressed* – Copy and paste from the project narrative.
  - b. *Organizational Goals Impacted* – Compare the project objectives and metrics to your Organizational Goals and/or Key Performance Indicators (KPIs) and list all of them that have been impacted by the work of the project
  - c. *Alignment Score* - # of Community Needs + # Organizational Goals
  
3. Financial Achievement section
  - a. *Total Allocated Value* for the project across the DYs: Category 1 or 2 + 3
  - b. *Total Achieved in the DY* (not counting carry forward \$).
  - c. *Financial Score* = 1 point for every \$1M Total achieved across the DYs (round down)
  
4. Achievement section
  - a. *Dollars Carried Forward* = \$ Allocated - \$ Achieved across the DYs. Informational only – does not impact score
  - b. *% Achieved in the DY* = \$ Achieved / \$ Allocated.
  - c. *Achievement Score* = 1 point for each 25% per DY  
(0 pt. = 0%-24%, 1 pt. = 25%-49%, 2 pt. = 50%-74%, 3 pt. = 75%-99%, 4 pt. = 100%)
  
5. Triple Aim section
  - a. Rate the Project Impact for each of the Triple Aims:
    - 1) Very Little: No specific interventions in a Triple Aim section
    - 2) Some: Interventions without measureable improvement over baseline
    - 3) Moderate: Interventions with improvement over baseline but not meeting goal
    - 4) High: Interventions with improvement meeting goal for limited population
    - 5) Very High: Interventions with improvement meeting goal for large population
  - b. *Quality and Experience of Care:*  
Give specific Quality and Patient Satisfaction metric results to justify score
  - c. *Population Health Management:*  
Give specific Population Health and Care Transition metric results to justify score
  - d. *Reduction of Cost of Care:*  
Give specific Cost, LOS and Avoidable Hospital Visit metric results to justify score  
Use the “Standard Cost Savings” table below to estimate cost reduction.

6. *Our Key to Success*

Briefly describe what has been the primary key to the project’s success.

7. Metric section

- a. Gather your QPI and Cat 3 data from various sources and record in these grids.

QPI	Result	Goal
DY3		
DY4		
DY5		
DY6		

Cat 3	Result	Goal
DY3 (BL)		No Goal
DY4 (PY1)		
DY5 (PY2)		
DY6 (PY3)		

- b. *QPI*: Right-click graph and choose Edit Data, and then Enter QPI Results and Goals.
- c. *Cat 3*: Right-click graph and choose Edit Data, and then Enter Cat 3 Results and Goals. For most project’s category 3 metrics, the baseline was established in DY3 so there was no goal that year. If your project had a different baseline and performance periods, make adjustments to the column with DY labels.
- d. Adjust chart titles, axis scales, and number formats as needed

8. Future Possibilities section

- a. *Improvements Still Needed*  
Briefly describe Barriers, Unmet Needs, Opportunities for Improvement and Possible Future Adjustments
- b. *Replication Across the State*  
Briefly describe project interventions that could be replicated across the state and possible barriers to replication

In the *Reduction of Cost of Care* section, estimate annual savings by multiplying the number of avoided or redirected hospital visits by the estimated savings per visit shown in the Standard Cost Savings table below. These estimated savings figures are based on JPS hospital 2016 cost-to-charge ratios (5%) for estimating Variable Direct Costs (VDC) per visit type.

Standard Cost Savings for Project Evaluation	VDC Savings
ED Visit Avoided completely	\$150
ED Visit Redirected to Urgent Care	\$115
ED Visit Redirected to Same Day Clinic	\$140
BH ED Visit Avoided Completely	\$125
BH ED Visit Redirected to Same Day Clinic	\$105
IP Admission / Readmission Avoided completely	\$2,800
ACSC Admission Avoided completely	\$1,650
Inpatient Admission Redirected to Observation	\$1,450
Observation Visit Avoided Completely	\$625
Observation Visit Resolved in the ED	\$465

## Exercise 1: Triple Aim Impact Metrics – Which Section?

Some metrics can be used to measure the impact of interventions in more than one of the Triple Aim sections: Quality and Patient Experience of Care, Population Health and Care Transitions, and Reduction of Cost of Care. An example of a multi-section metric: **All Cause 30 Day Readmissions**

- Readmissions is traditionally considered a *Quality of Care Outcome* metric, because if patients are discharged before they are stabilized they could readmit.
- Readmissions can also be a *Population Health and Care Transition* metric, because proper discharge planning and scheduling of follow-up ambulatory care can reduce readmissions.
- Readmissions can also be a *Reduction of Cost of Care* metric, because every readmission avoided reduces the cost of care.

*Classify which of the metrics listed below are appropriate for each of the Triple Aim sections. Some metrics are appropriate for more than one section, so check all that apply.*

	Quality and Experience of Care	Population Health and Care Transition	Reduction of Cost of Care
Increase the percentage of Inpatients that have a follow-up ambulatory appointment within 30 days of discharge.			
Increase percentage of patients over the age of 50 who have a colorectal screening test within the last 5 years.			
Decrease the number of Falls with Injuries per 1000 inpatient days.			
Decrease the number of Inpatient Admissions for Ambulatory Care Sensitive Conditions.			
Improve your CG-CAHPS Patient Satisfaction score for Overall Rating of Provider.			

List the QPI, Category 3 metrics and measurable Category 1 or 2 milestones from your project over the DYs and identify their appropriate Triple Aim sections.

	Quality and Experience of Care	Population Health and Care Transition	Reduction of Cost of Care

## Exercise 2: Effective Triple Aim Impact Statements

In order to justify an Impact Score from 1: Very Little Impact to 5: Very High Impact, you need to be able to quantify or measure the impact your project interventions have had on patient care, so use actual metric results and/or numbers of patients impacted to demonstrate improvement over time.

A “**Very Effective**” impact statements has all **3** of the following elements: **1)** identifies specific interventions (*what you changed*) with **2)** demonstrated outcomes (*how it improved patient care*) and **3)** quantifiable data points showing improvement from pre-intervention to post-intervention.

The example statements below show different levels of effectively communicating level of impact.

- Less Effective: (*describes an intervention without outcomes or quantifiable results*)  
“We implemented LACE+ scores in our EMR to identify patients at high risk for readmission.”
- Somewhat Effective: (*has 2 out of 3 elements described above*)  
“We implemented LACE+ score in our EMR and reduced the readmission rate for high risk patients from 21.6% to 11.7% over two years.”
- Very Effective: (*has all 3 elements described above*)  
“By implementing LACE+ scores in our EMR, we were able to identify patients with high readmission risks who needed additional resources after discharge. This helped us reduce the readmission rate for high risk patients from 21.6% to 11.7% over two years.”

**Exercise:** Rate the Effectiveness of each of the Impact statements and rewrite each statement to improve the reader’s ability to understand the quantifiable impact on patient care. Make up improvement numbers when none are provided. Even a “Very Effective” statement can be improved.

1. We reduced our ACSC ED Utilization Rate from 16.4% to 12.5% - exceeding our DY5 goal of 14.4%	Very Effective	Somewhat Effective	Less Effective
2. We started making reminder phone calls to our patients 3 days before their next appointment.	Very Effective	Somewhat Effective	Less Effective
3. The patients enrolled in our “Readmission Avoidance” home care program had fewer readmissions in the 6 months after participating in the program compared to the six months before enrollment. This was an estimated cost savings of \$270,000.	Very Effective	Somewhat Effective	Less Effective