An Introduction to DSRIP
“DSRIP 101”

Presented by the AMCH PPS Project Management Office
Learning Objectives

- **What is DSRIP?**
  - Background
  - Goals

- **Who is AMCH PPS?**
  - Partners
  - Governance structure
  - Domains/Projects/Workstreams
  - Speed and Scale

- **What is population health?**
  - The old way vs. the new way
  - Social determinants of health

- **Who are our patients?**
  - Activating patients in their care
DSRIP Acronyms

AHI- Adirondack Health Institute
AFBHC- Alliance for Better Health Care, LLC
AMCH PPS- Albany Medical Center Hospital PPS
CBO- Community Based Organization
CMS- Centers for Medicaid & Medicare Services
CNA- Community Needs Assessment
DY- DSRIP Delivery Year
MRT- Medicaid Redesign Team
NYS- New York State
NYSDOH- New York State Department of Health
PCP- Primary Care Physician
PPS- Performing Provider System
VBP- Value-Based Payment

and of course....
What is DSRIP?

**Delivery System Reform Incentive Payment Program**

DSRIP’s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing **avoidable** hospital use by 25% over 5 years.
Is DSRIP a Grant Program?

• Up to $6.42 billion New York State dollars are allocated to this program statewide

• Unlike typical grants, DSRIP funds are earned based upon achieving predefined results in system transformation, clinical management and population health.

What is population health?
What is Population Health?

“The health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

**The Old Way**
(Fee for Service)

- Volume
- “More is better”
- “More services, more income”
- Focus on medical care only (20%)
- The sick business
- Treating an individual’s acute symptoms

**The New Way**
(Population Health)

- Value
- “Less is more”
- “No outcome, no income”
- Focus on social determinants of health (80%)
- The health business
- Influencing the well-being of the larger population
What Are Social Determinants of Health?

Key Social Determinants of Health

**Economic Stability**
- Poverty
- Housing Security and Stability
- Employment
- Food Security
- Transportation

**Education**
- Early Childhood Education and Development
- High School Education
- Enrollment in Higher Education
- Language and Literacy

**Social and Community Context**
- Social Cohesion
- Civic Participation
- Perceptions of Discrimination and Equity
- Incarceration/Institutionalization

**Neighborhood and Environment**
- Affordable/Quality Housing
- Environmental Conditions
- Access to Healthy Foods
- Crime and Violence

**Health and Health Care**
- Access to Health Care – gaining entry into Health System
- Access to Primary Care/Trusted Provider
- Health Literacy

What Groups Can Be Addressed by Population Health?

- Age groups
- Ethnic groups
- Employees
- Disabled persons
- Prisoners
- Any other defined group
What Is Needed to Move Toward Population Health?

| Education   | • Leadership  
|             | • Workforce  
| Engagement  | • Practitioners  
| Technology  | • Registries  
| TIME!       | • Patient Tools  

Population Health will require a multi-year cultural transformation...
Background of DSRIP

• 1115 Waiver – NYS to reinvest federal savings in Medicaid delivery system

• In April 2014, Governor Cuomo announced that NYS and CMS finalized an agreement
  – NYS requested $16 billion, CMS approved about $8 billion

• Payments are based on performance on process and outcome milestones of CMS-approved projects.
DSRIP is NOT...

... about cutting Medicaid Services!

The goals of DSRIP are to **create a more efficient and effective healthcare system** to improve patient outcomes and experience, while lowering the costs of healthcare.
What are the Goals of DSRIP?

• Reduce avoidable ED use and inpatient admissions by 25%

• Enhance the patient experience & clinical outcomes

• Improve key population health measures

• Minimize the system-wide cost of care

• Provide a community-based approach to care

The Quadruple Aim
Why is DSRIP Important?

National healthcare spending continues to rise, at an unsustainable rate. Despite spending the most on healthcare, U.S. health outcomes are often worse than those of nations spending far less.
Medicaid Spending in NYS

NYS Statewide Total Medicaid Spending (CY2003-2013)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th># of Recipients</th>
<th>Cost per Recipient</th>
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<tbody>
<tr>
<td>2003</td>
<td>4,207,573</td>
<td>$8,469</td>
</tr>
<tr>
<td>2004</td>
<td>4,594,667</td>
<td>$8,472</td>
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<tr>
<td>2005</td>
<td>4,713,617</td>
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<td>4,730,167</td>
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<tr>
<td>2007</td>
<td>4,622,782</td>
<td>$9,113</td>
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<tr>
<td>2008</td>
<td>4,627,242</td>
<td>$9,499</td>
</tr>
<tr>
<td>2009</td>
<td>4,911,408</td>
<td>$9,574</td>
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<tr>
<td>2010</td>
<td>5,212,444</td>
<td>$9,443</td>
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<tr>
<td>2011</td>
<td>5,398,722</td>
<td>$9,257</td>
</tr>
<tr>
<td>2012</td>
<td>5,598,237</td>
<td>$8,884</td>
</tr>
<tr>
<td>2013</td>
<td>5,702,568</td>
<td>$8,504</td>
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*Projected Spending Absent MRT Initiatives was derived by using the average annual growth rate between 2003 and 2010 of 4.28%. Excluded from the 2013 total Medicaid spending estimate is approximately $5 billion in “off-line spending (DSH, etc.)"
Impact of the MRT on Medicaid Spending

Nearly a $1000 reduction in spending per recipient per year since MRT implemented
Addressing the Cost of Healthcare Through Value-Based Payment (VBP)

- VBP is a broad concept that involves paying providers for value in healthcare services

  Value vs. Volume

- Moving from fee for service to value-based care promotes **quality** and **value** of healthcare services

- Pay-for-performance programs rewards improvements in quality metrics

- Helping control healthcare costs
Learn More About VBP from NYSDOH

The links below provide a concise view of the transitions from the current fee-for-service model to Value-Based Payments.

VBP for the public:
- English: https://www.youtube.com/watch?v=9D4M-QsaNfM&t=4s
- Spanish: https://www.youtube.com/watch?v=Aq4sJq8Xj4o

VBP for providers:
- English: https://www.youtube.com/watch?v=_mvfd5GXvVs&t=4s
- Spanish: https://www.youtube.com/watch?v=ubrHIKKc1Cs
DSRIP Program Design

NYS created 25 “Performing Provider Systems (PPS),” each with a lead entity responsible for facilitating collaboration across the region in order to implement selected projects.
The AMCH Performing Provider System

The PPS 5 County Area:

- Albany (Central Hub)
- Columbia (Southern Hub)
- Greene (Southern Hub)
- Saratoga (Northern Hub)
- Warren (Northern Hub)
Who is the AMCH PPS?

Our partnering provider types include:

With Albany Medical Center Hospital as the lead organization, the AMCH PPS consists of more than 175 community healthcare providers.
AMCH PPS New Organization

AMC Board of Directors

C. Burke, F. Venditti, M.D., S. Frisch, M.D., F. Spreer-Albert, & G. Hickman

Center for Health Systems Transformation Project Management Office
L. Filhour, PhD, RN, Chief Executive Officer, K. Manjunath, MD, Medical Director, Christine McIntyre, Chief Operating Officer, Lauren Ayers, Chief Financial Officer

PAC Executive Committee

Finance  WCC  CCHLC  TDMC  CQAC  A/C  CCAC

Project Advisory Committee

Performing Provider Organizations and Providers
4 Domains in DSRIP

**Domain 1**
Governance, measurement on completion of project plan

**Domain 2**
Measurement of system transformation

**Domain 3**
Disease focused clinical improvements

**Domain 4**
Population-wide strategy implementation; Prevention Agenda improvements
11 Organizational Sections

- Workforce Strategy
- Governance
- Financial Sustainability
- Cultural Competency & Health Literacy
- IT Systems & Processes
- Performance Reporting
- Practitioner Engagement
- Population Health Management
- Clinical Integration
- Budget
- Funds Flow
Community Needs Assessment (CNA)

A CNA tells us about a community’s:

- People
- Resources
- Needs
Community Needs Assessment (CNA)

The PPS used a CNA to determine:

Using this information, along with information from focus groups and listening sessions, AMCH PPS selected 11 projects considered most valuable to the community.

33 other projects were available for selection. PPSs around the state are working on these initiatives.
Want to Learn More About Your Community?

Our Community Needs Assessment, performed in collaboration with the Alliance for Better Health Care, LLC in 2014, can be found on our website, under “DSRIP Planning Documents.”

www.albanymedpps.org
## AMCH PPS 11 Selected Projects

<p>| 2.a.i | • Create an Integrated Delivery System focused on Evidence based medicine and Population Health Management |
| 2.a.iii | • Health Home At-Risk Intervention Program: proactive management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary care and Support Services |
| 2.a.v | • Create a Medical Village/ Alternative Housing Using Existing Nursing Home Infrastructure |
| 2.b.iii | • ED Care Triage for At-Risk Populations |
| 2.d.i | • Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/ non-utilizing Medicaid Populations into Community Based Care |
| 3.a.i | • Integration of Primary Care and Behavioral Health Services |
| 3.a.ii | • Behavioral Health Community Crisis Stabilization Services |
| 3.b.i | • Evidence-Based Strategies for Disease Management in High Risk/ Affected Populations (Adults Only) |
| 3.d.iii | • Implementation of Evidence Based Medicine Guidelines for Asthma Management |
| 4.b.i | • Promote tobacco use cessation, especially among low SES populations and those with poor mental health |
| 4.b.ii | • Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings |</p>
<table>
<thead>
<tr>
<th>Domain 1: <strong>Organizational Components</strong></th>
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<tr>
<td>Governance</td>
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<tr>
<th>Domain 2: <strong>System Transformation</strong></th>
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<th>Domain 3: <strong>Clinical Improvement</strong></th>
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<th>Domain 4: <strong>Population Wide Projects</strong></th>
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**Better care, less cost**

A. Create Integrated Delivery Systems
   1. Create IDS for PHM
   2. Health Home At-Risk
   3. Create Medical Village in Nursing Homes

B. Care Coordination & Transitional Care Programs
   4. ED Care Triage for At-Risk Population

D. Utilizing Patient Activation to Expand Access
   5. Implement Patient Activation Activities (PAM)

A. Behavioral Health
   6. Integration of PC & BH services

B. Cardiovascular Health
   7. BH community crisis stabilization services

8. E-B strategies for managing Hypertension

C. Asthma
   9. Implement E-BM guidelines

B. Prevent Chronic Diseases
   10. Promote tobacco use cessation among low SES populations

11. Increase Access to Preventive Care and Management (Cancer)

**Domain 2, 3 & 4: **Project Components**

Domain 1: Organizational Components
What does “Speed and Scale” mean?

PPS (not partner) commitments made for each project...

**Speed**
- A projected timeframe for goal completion

**Scale**
- Minimum # of providers/sites required for project success
- Anticipated # of patients reached by each project

Speed and scale projections were made during the submission of the application and cannot be changed. These projections were made before any milestone requirements were released to the PPSs, making it challenging to accurately predict... and in some cases, to reach. The PPS is expected to reach 80% of its projected speed and scale objectives.
Who Are the Patients We Serve?

AMCH PPS serves

~52,000 Medicaid Consumers

~17,000 Uninsured Consumers

~69,000 Total Consumers

Patients are “assigned” to the PPS through a process called attribution.
How Does Attribution Work?

- Attribution is fluid and complex, not a fixed number
- Based on providers in our network providing services to patients
- Behavioral health, PCP, and Health Home services are key
- Patient services do not change if they are not attributed
- Attribution is necessary to trend performance and quality of care

AMCH PPS is committed to involving consumers in settings beyond the medical office
Consumer and Community Affairs

AMCH PPS recognizes the need for consumer input and feedback and seeks this through multiple initiatives:

- **Community Forums**
- **Working with social services agencies**
- **Collaboration with neighboring PPSs to work with patients in key service areas around the region**
- **Consumer Listening Sessions**
- **Meeting patients “where they’re at”**
What Is a Community Based Organization?

Non-profit groups with diverse skill sets and expertise that work at a local level to improve life for residents

Often serve disadvantaged populations in accessing services to meet their basic needs

Staffed primarily by community members who understand the needs of their clients

Focus on building equity across society in all sectors- healthcare, environment, education, etc.

Providers who complete the continuum of care (mental health, OASAS clinics)
Cultural Competency and Health Literacy

Serving patients as individuals through culturally and linguistically appropriate services is essential to system transformation. AMCH PPS will...

- Plan provider trainings
- Provide information and materials appropriate for various health literacy levels
- Encourage organizational attention to the importance of these issues
- Support policy development, promoting a diverse workforce, language access services
Who Needs to Know About DSRIP?

Everyone!

It is essential that DSRIP is understood by and approached through all sectors to ensure a community-wide transformation of the healthcare system.
Why You Need to Know About DSRIP

Your organization has chosen to partner with us!

To truly transform the healthcare delivery system, we need all providers, healthcare workers, and consumers to participate in transformation activities.
DSRIP Funding

PPS receives funding from NYS based on reporting (DY1-2), then performance (DY3-5).

PPS flows funds to partners based on achievement of contract metrics associated with selected projects.

NYS has capped CBO funding at 5% of total funds flow.
Can a Provider Participate in More Than One PPS?

**YES!**

Many of the health care providers and CBOs in the AMCH PPS are participating in our neighboring PPSs as well.

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<tr>
<th>Regional PPSs and their associated counties</th>
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<tbody>
<tr>
<td><strong>Albany Medical Center Hospital PPS (AMCH PPS)</strong></td>
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## What Can Patients Do?

| Work with their care team | • See your PCP or get a PCP if you don’t have one  
|                           | • Ask about care coordination services  
|                           | • Ask how you can become more engaged in your care |
| Attend public forums      | • Hear more about how DSRIP is transforming care in the region |
| Participate in listening sessions | • Tell us about your experiences using the healthcare system and your ideas for improving it |
| Learn more!              | • Visit our website www.albanymedpps.org  
|                           | • http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/ |
The Opt Out Process

Medicaid members can Opt-Out of DSRIP at any time

NYSDOH sent 6+ million enrollees information about Opt-Out

More information can be found on the NYSDOH website

• http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/consumers.htm
What Happens When a Member Opts Out?

Opting-Out **DOES** mean:

Member’s Medicaid data cannot be shared with the PPS

Opting-Out **DOES NOT** mean:

Member’s services will change
Patient Activation

**Knowledge** + **Skills** + **Confidence** = **Activation**

*Individuals possessing these three domains are actively engaged in their health and change behaviors where needed to achieve better health outcomes.*

**Patient Activation Tells Us**

- Who needs more support
- How to measure performance and to have a marker for quality care
- How to tailor the support and information our patients need to be successful self-managers
Patient engagement is essential to healthcare improvement. For the purposes of DSRIP, however, each project defines “actively engaged” patients with a distinct criteria.

For example:

**Project 3.a.i (Model 1)**

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Integration of primary care and behavioral health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actively Engaged Definition</td>
<td>The total number of patients receiving appropriate preventive care screenings that include mental health/substance abuse.</td>
</tr>
</tbody>
</table>
Collaboration... The Key to Success

- Other Public Health Initiatives
- PPSs
- Sectors
- Projects
- Providers
- Patients
- Religious Organizations
- Education System
Now We Need Your Feedback!

Please use the link below (also in the email regarding metric IDS_R9) to provide your feedback on how we can improve this presentation and ensure we are all working toward the same vision!

http://conta.cc/2i2nFl1

Thank you!
Questions??

Contact us!

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DSRIP@mail.amc.edu

Or visit our website, www.albanymedpps.org