

**AMAZING  
THINGS  
ARE  
HAPPENING  
HERE**

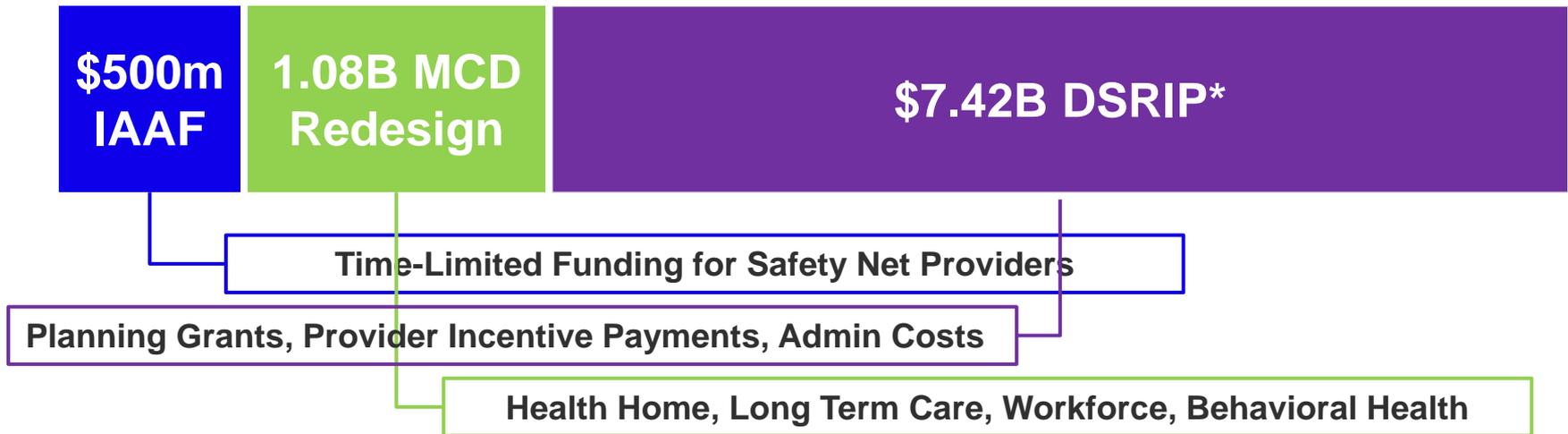
# **Overview of DSRIP and the NYP PPS**

**As of 12/28/2016**

# 2014 NYS Medicaid Waiver Approved

In 2014, Governor Andrew Cuomo announced that New York State and CMS finalized agreement on the Medicaid Redesign Team Waiver Amendment.

This allows NYS to invest \$9 Billion in:



\*7.42B includes \$1B safety net equity fund from New York State

# NYS DSRIP Vision & Goals

***Attribute geographic populations to performing provider systems (PPS) for care management and coordination across the care continuum***

## Specific Goals

1. Reduce avoidable hospitalizations and emergency department visits by 25% over 5 years
2. Transform the Medicaid delivery system to be value-based
3. Achieve Triple Aim (improved health, improved quality, lower costs)
4. Promote community-level collaboration
5. Improve population health

# NYS DSRIP Key Elements

## Patient Centered

Improving patient care & experience through a more efficient, patient-centered, coordinated system.

## Transparent

Decision making process takes place in the public eye; processes are clear and aligned across providers.

## Collaborative

Collaborative process reflects the needs of the communities and inputs of stakeholders.

## Accountable

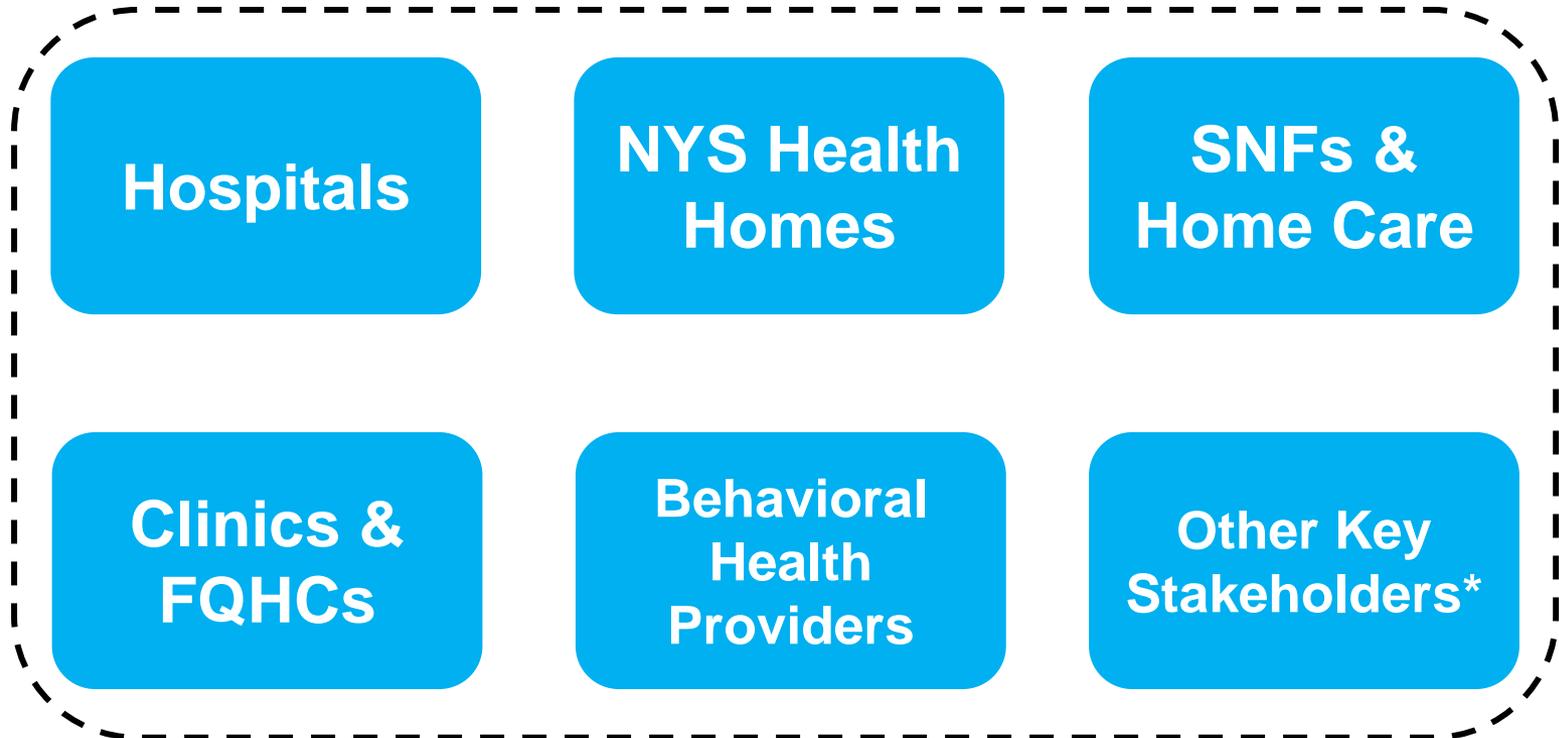
Providers are held to common performance standards, deliverables, and timelines.

## Value Driven

Focus on increasing value to patients, community, payers, and other stakeholders.

# Performing Provider Systems (PPS)

Coalitions of major public general hospitals and other safety net providers organized to ensure coordinated care throughout continuum, reduce preventable inpatient and ER volume, expand primary and preventative care, take responsibility for defined populations.



There are 25 PPSs across NYS.

NewYork-Presbyterian is leading one PPS.

# NewYork-Presbyterian PPS Overview

*~90,000 Attributed Lives*

*~80+ Collaborators*

*~\$97M over 5 years*

*10 interventions*

*System Transformation  
(2+)*

*Clinical Improvement  
(2+)*

*Population-Wide Prevention  
(1+)*

# NYP PPS Projects

Project	Key Features
Integrated delivery system	<ul style="list-style-type: none"><li>• Integrated governance structure</li><li>• Standardized clinical protocols and referral mechanisms</li><li>• Integrated IT and reporting infrastructure</li><li>• Level III PCMH</li></ul>
ED Care Triage	<ul style="list-style-type: none"><li>• Enhanced Patient Navigators embedded in ED</li><li>• Connections to PCPs for &lt;30 day follow-up visits</li><li>• Warm handoffs to CBOs</li></ul>
Ambulatory ICU (peds and adults)	<ul style="list-style-type: none"><li>• Enhanced care coordination for high-risk patients</li><li>• Multi-disciplinary care teams, including specialists</li><li>• CHW home visits</li></ul>
Care Transitions to Reduce 30-Day Readmissions	<ul style="list-style-type: none"><li>• Targeted RN care coordinators for most at-risk</li><li>• Warm handoffs to post-acute providers and PCPs</li><li>• Embedded pharmacy support</li><li>• Follow-up phone calls</li></ul>

# NYP PPS Projects

Project	Key Features
Behavioral Health and Primary Care Integration	<ul style="list-style-type: none"><li>• Integrated primary care teams into NYSPI and NYP clinics</li><li>• Additional NPs for expanded capacity</li></ul>
Behavioral Health Crisis Stabilization	<ul style="list-style-type: none"><li>• Embedded care teams in CPEP, mobile crisis</li><li>• CHWs home visits</li></ul>
HIV Center of Excellence	<ul style="list-style-type: none"><li>• Enhanced care coordination for high-risk patients</li><li>• Enhanced relationships with pharmacies and CBOs</li><li>• CHW home visits</li></ul>
Integration of Palliative Care into PCMHs	<ul style="list-style-type: none"><li>• Palliative care teams (WC + CU) integrated into PCMH</li><li>• Additional palliative care training for ACN and community PCPs</li></ul>
Reduce HIV Morbidity & Promote Tobacco Use Cessation	<ul style="list-style-type: none"><li>• Outreach through community-based organizations to reconnect individuals with primary care and smoking cessation treatment</li></ul>

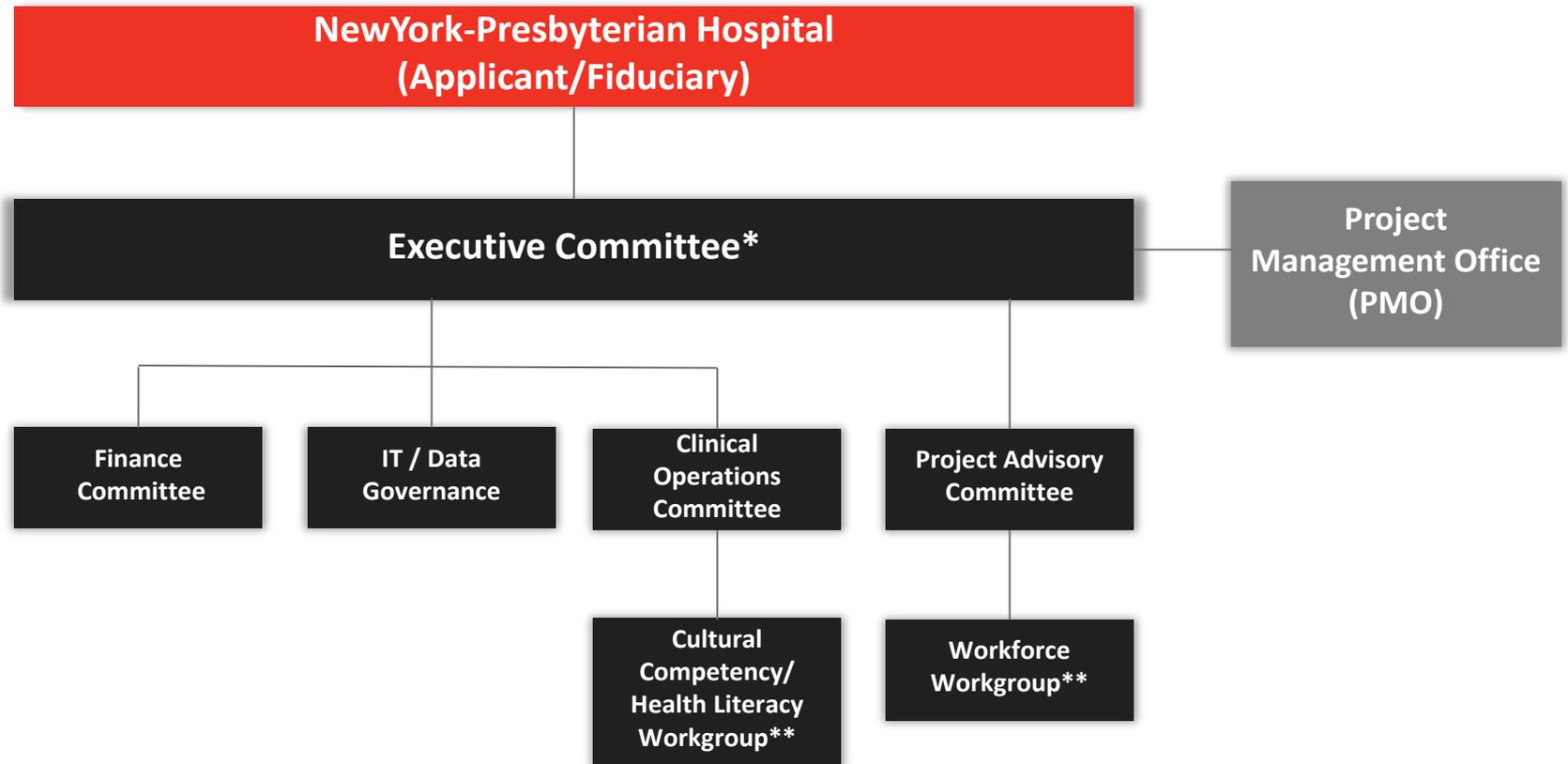
# NYP PPS Collaborators

- **FQHCs:** Community Healthcare Network, Charles B. Wang CHC, Harlem United
- **Independent MDs:** 4 Primary Care Physicians in Washington Heights
- **Behavioral Health:** NYS Psychiatric Institute & BH CBOs
- **Post-Acute:** VNSNY, MJHS, Isabella, ArchCare
- **Community-Based Organizations:** Scattered across Manhattan and Southern Bronx

*For more information, please visit:*

*[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/pps\\_network\\_lists/ny-presby\\_hospital.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_network_lists/ny-presby_hospital.htm)*

# NYP PPS Governance Structure



*\*Also responsible for Audit/Compliance*

*\*\*Ad Hoc Membership*

# Resources

- [www.nyp.org/pps](http://www.nyp.org/pps)
- More information on DSRIP, including a copy of the NYP-led PPS's design grant application, are available at: [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/)
- DSRIP Program Group on LinkedIn – “New York State Delivery System Reform Incentive Payment (DSRIP) Program Group”
- Email: [ppsmembership@nyp.org](mailto:ppsmembership@nyp.org)