DSRIP Population Health Projects

May 2014

Office of Public Health
NYS Department of Health

DSRIP

- Delivery System Reform Incentive Payments totaling $6.42 billion over five years as part of the state Medicaid Reform
- Goal is to fundamentally restructure the state's health care delivery system by reinvesting in the state's Medicaid program with the primary goal of reducing avoidable hospital use by 25% in five years.
- Payments will be made to performing provider systems (PPSs) based on achieving predefined results in system transformation, clinical management and population health.

PERFORMING PROVIDER SYSTEMS

Will be required to collaborate with partners to conduct a community needs assessment, identify strategies to address those needs and develop and implement projects that incorporate those strategies. PPSs will be required to develop and implement at least 5 but no more than 10 projects in three domains:

- Domain 2: System Transformation
- Domain 3: Clinical Improvement
- Domain 4: Population Wide Projects based on NY's Prevention Agenda

DSRIP TIME FRAME

Year 0: April 1, 2014 – March 31, 2015

- Planning Year when Performing Provider Systems conduct planning, community needs assessments and project development
- Letters of Intent already past due
- Design Grant Applications Due June 26th

Year 1: April 1, 2015 – March 31, 2016

- First year of project implementation

Domain 3: Clinical Improvement Projects

B.	**Cardiovascular Health—Implement Million Hearts Campaign (adults)**
3.b.i	Evidence based strategies for disease management in high risk/affected populations
3.b.ii	Implementation of Evidence-based strategies in the community to address chronic disease – primary and secondary prevention strategies
C	**Diabetes Care (adults)**
3.c.i	Evidence based strategies for disease management in high risk/affected populations
3.c.ii	Implementation of evidence-based strategies to address chronic disease – primary and secondary prevention strategies
D.	**Asthma**
3.d.i	Develop evidence-based medication adherence programs (MAP)– asthma medication
3.d.ii	Expansion of asthma home-based self-management program
3.d.iii	Evidence based medicine strategies for asthma management
E.	**HIV/AIDS**
3.e.i	Comprehensive strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for Management of HIV/AIDS
F.	**Perinatal Care**
3.f.i	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

Domain 4: Population-wide Projects: New York's Prevention Agenda

B.	**Prevent Chronic Disease**
4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health. (Focus Area 2; Goal #2.2)
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This strategy targets chronic diseases that are not included in domain 3.b., such as cancer)
C.	**Prevent HIV and STDS**
4.c.i	Decrease HIV morbidity
4.c.ii	Increase early access to, and retention in, HIV care
4.c.iii	Decrease STD morbidity
4.c.iv	Decrease HIV and STD disparities
D.	**Promote Healthy Women, Infants and Children**
4.d.i	Reduce premature births in New York State

Community Needs Assessment

- Comprehensive assessment of demographics and health needs of population to be served, and health care resources and community based service resources available in service area

- Forms the basis and justification to guide the transformation of the health care system

- The Performing Provider System needs a solid understanding of the broader health status and health care system in the geographic region in which they are functioning to effectively select the meaningful projects.

- CNAs should build on recently completed community health assessments completed by local health departments and by community service plans completed by hospitals tied to state's Prevention Agenda

Components of a Community Needs Assessment

A. Description of the Community to Be Served

B. Description of health care and community resources to be Transformed to Meet the Needs of the Population

C. Identification of Main Health and Health Care Challenges Facing the Community

D. Summary of Assets and Resources to be Mobilized to Address Needs

E. Summary of DSRIP Projects to Be Implemented

F. Documentation of Process and Methods Used to Conduct Assessment and to Obtain Input from Community

Resources

- DSRIP Data Page

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_performance_data.htm

- Prevention Agenda Resources, including recently completed Community Health Improvement Plans and Community Service Plans

http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

- New York State Office of Mental Health Behavioral Health Planning Data for DSRIP Project

http://www.omh.ny.gov/omhweb/special-projects/dsrip/index.html