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Improving Care Delivery: Learning from New York State's DSRIP Initiative

John Harris, Director, Veralon

Idette Elizondo, Manager, Veralon

As a Zen master might say, "Change must come from within." Everybody can point to fundamental problems with healthcare delivery, especially for low-income populations. But managed-care rewards and penalties and other efforts have not been enough to transform the delivery system.

New York State is working to encourage "change from within" through its Delivery System Reform Incentive Payment (DSRIP, pronounced "DISrip") program for Medicaid patients. New York is one of six states implementing DSRIP initiatives, joining California, Texas, New Jersey, Kansas, and Massachusetts.

The primary goal of the New York program is to reduce avoidable hospital admissions and emergency department (ED) visits in Medicaid by 25 percent over five years. The state is tapping $6.4 billion in federal funds to help achieve this objective.

Although DSRIP is focused on transforming care delivery for New York's 5.8 million Medicaid recipients, it also may offer lessons for health care's broader transition to value-based care models. As we have assisted clients in completing the various DSRIP applications, we have developed some initial insights that may have broader applicability.

Attribution is challenging. As with Medicare's accountable care organizations (ACOs), Medicaid patients under DSRIP don't choose a provider. The patients are "attributed" to a performing provider system (PPS) based on where they previously received care. With attribution systems, when patients go elsewhere for care, the PPS (or ACO) is still responsible for managing the quality and cost of their care. This challenging operational environment requires keeping patients satisfied and loyal.

Successful innovation requires a marriage of experiences. Connecting those on the clinical frontlines with the perspectives of administrators who are familiar with new payment initiatives can result in the identification of new leverage points and ideas for innovative, well-anchored programs.

Details should be addressed from the start. The view from 30,000 feet isn't focused enough to choose initiatives that will achieve the ultimate goals of the program. Success requires drilling into the details of project structure, staffing, operating costs, and likely results, to know what can realistically be achieved—so organizations should start that process early.

Effective communication—whether about test results, ED visits, patient education needs, or patient status changes—is at the heart of effective care coordination.

The "soft stuff" is critical. Hospitals often are too focused on clinical complexity. Much of the opportunity to achieve better population health and savings lies in less clinical functions that tie into social services not typically addressed by hospitals and physicians. Transportation, nutrition, patient education, and family support systems are critical not only for Medicaid populations, but for the general population as well. Addressing these issues will require engaging new partners, such as community social service organizations.

Effective communication—whether about test results, ED visits, patient education needs, or patient status changes—is at the heart of effective care coordination. Building an IT infrastructure that crosses organizational boundaries may require everything from creating "translator" interfaces between systems to dealing with turf wars. While all this is in process, it may be necessary to fall back on basic communication tools such as phones and flow sheets.

DSRIP is very much a work in progress. We will have more to share as the program develops further.

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877.676.3600 www.veralon.com info@veralon.com