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

In order to be eligible for this project, a PPS must already be pursuing 10 projects, demonstrate its network capacity to handle an 11th project, and evaluate that the network is in a position to serve uninsured (UI), non-utilizing (NU), and low utilizing (LU) populations. Any public hospital in a specified region has first right of refusal for implementing this 11th project. Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project. Finally, in order to participate in pay-for-reporting outcome metrics in Demonstration Years (DY) 4 and 5, the PPS will submit data as specified.

Project Objective: The objective of this 11th project is to address Patient Activation Measures® (PAM®) so that UI, NU, and LU populations are impacted by DSRIP PPS' projects. Feedback from the public comment period resulted in the state to include UI members in DSRIP, so that this population benefits from a transformed healthcare delivery system. Please refer to the body of literature found below on patient activation and engagement, health literacy, and practices to reduce health care disparities:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/
http://content.healthaffairs.org/content/32/2/223.full
http://www.hrsa.gov/publichealth/healthliteracy/
http://www.health.gov/communication/literacy/
http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program.page
http://www.hrsa.gov/culturalcompetence/index.html
http://www.nih.gov/clearcommunication/culturalcompetency.htm

Project Description: This project is focused on persons not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care services. The PPS will be required to formally train on PAM®, along with base lining and regularly updating assessments of communities and individual patients. This project encapsulates three primary concepts, which drive the requirements for this project:

- Patient activation
- Financially accessible health care resources
- Partnerships with primary and preventive care services

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.

2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.
3. Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.
4. Survey the targeted population about healthcare needs in the PPS' region.
5. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.
6. Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).
    - This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.
    - Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.
7. Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.
8. Include beneficiaries in development team to promote preventive care.
9. Measure PAM® components, including:
    - Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.
    - If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM® survey and designate a PAM® score.
        - Individual member score must be averaged to calculate a baseline measure for that year's cohort.
        - The cohort must be followed for the entirety of the DSRIP program.
    - On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.
    - If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.
        - The PPS will NOT be responsible for assessing the patient via PAM® survey.
        - PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.
    - Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.
10. Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.
11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage community health care resources (including for primary and

preventive services) and patient education.

12. Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.
13. Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.
14. Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive health care services and resources.
15. Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.
16. Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.
17. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. The project description should consider three primary activation concepts: *patient activation*, *financially accessible health care resources*, and *partnerships with primary and preventive care services.*

Simply having health insurance is not enough to ensure improved health outcomes or appropriate use of the health system. A lack of familiarity with that system, coupled with social and cultural barriers to care, results in avoidable utilization of high-cost health care resources among some uninsured (UI), and/or low- and non-utilizing Medicaid recipients (LU/NU). To reduce avoidable ER visits and admissions (and address the overall DSRIP goal of a 25% reduction in avoidable hospital use), individuals must actively engage in managing their own health. The implementation of this project will assist individuals to take charge of their health ("activation") and move along a continuum to better health, reducing avoidable ER use and hospital admissions. The CNA documented barriers to access among uninsured and Medicaid recipients. By comparing Medicaid and uninsured respondents to countywide findings, significant disparities became evident. These populations have difficulty accessing healthcare because of the cost of physician visits and prescriptions; inconvenient office hours/appointment availability; difficulties finding physicians; and lack of transportation. Additionally, both cultural and linguistic barriers exist for many. These individuals experience greater levels of mental health problems and childhood obesity, and report a lack of leisure time. They are also more likely to skip/stretch prescription doses, use the ER and have difficulty getting care for their children. In regard to ER usage, Medicaid members had 119,932 total visits, of which 72% were potentially avoidable. Comparing the target population to the general population, 39.4% vs. 16.9% are in fair/poor health.While reaching this population can be difficult, the success of the PPS CBOs in doing so will strengthen this project. In collaboration with CBOs, navigators will be placed in community settings (housing sites, welfare offices, churches, barber

shops, markets, etc.) in identified hot spots, to reach individuals who have limited contact with the healthcare system. Navigators will assess individuals using PAM to determine their knowledge, skills and confidence for managing their health and healthcare, and monitor that level of activation. Navigators and peer counselors, trained in the Coaching for Activation method, will work with individuals to build awareness of the importance of prevention and early intervention among uninsured and LU/NU Medicaid recipients, and increase their confidence in using and managing their care. Navigators will connect those individuals with case management as necessary, and with their existing PCPs (if they have them) or financially and geographically accessible PCPs in private practice and community health clinics, all of whom will be trained in the concepts of patient activation and engagement. Culturally competent PPS CBOs will collaborate with and train other PPS members to ensure that once these linkages have been made, the connection will hold and individuals will advance in their activation and engagement. Additionally, uninsured individuals will be connected to appropriate insurance products to improve the financial accessibility of care.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population. Note: Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project.

With a population of 1.5 million, Suffolk County has approximately 240,000 Medicaid members and 168,618 uninsured. It is reported that about 29% of Medicaid recipients are NU, or LU. This equates to 69,381 for the PPS, bringing the total target population to 237,999. 36.2% of Medicaid recipients, 17.6% of uninsured and 9.0% of commercially insured have used an ER more than once in the past year. 8.9% of the target population relies on the ER for care vs. 3.3% of the total population. Medicaid members had a total of 119,932 ED visits, of which 72% (86,435) were potentially avoidable.There are four identified hot spots within Suffolk County where the majority of uninsured and Medicaid recipients reside: Riverhead/Hampton Bays reflects a particularly high level of need. Riverhead has seen significant growth in the Hispanic population over the past ten years. The area also has a substantial seasonal migrant farm worker population, many of whom are undocumented. Brentwood/Bay Shore/Central Islip has one of the highest Medicaid concentrations. Another hotspot for healthcare needs and unnecessary utilization is Huntington Station, a multi-cultural African-American, Hispanic, and White community that is less prosperous than Suffolk County in general. Patchogue has the highest concentration of total population living below the Federal Poverty Line of any community in Suffolk County. There is a high Hispanic population and the area has limited public transportation with particularly restricted hours on weekends. For the purposes of this project, efforts to activate and engage patients will be targeted to the hot spot communities through our network of participating CBOs, using navigators to identify, assess and triage individuals to case managers and PCPs based on their level of activation as measured by the PAM scale.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. Please demonstrate that the PPS has network

capacity to handle an 11th project and how the PPS is in a position to serve these UI, NU and LU populations. In addition, identify any needed community resources to be developed or repurposed.

Participating in this project are over 40 PPS members from across the continuum of care. PPS CBOs have demonstrated experience in successful outreach to the target population, and provide their services in a culturally competent manner. Building upon these resources, the PPS will expand and enhance the navigator/peer coaching staff, building on the current capacity of CBOs to reach more deeply into the target population. CBOs, already versed in cultural competency, will assist in providing training in cultural competence across the system. Efforts will be directed to navigators/coaches, case managers, PCPs, and ER staff. With the IDS project initiative developing a centralized case management function, the PPS will have the opportunity to enhance and coordinate existing community-based and MCO case management efforts to address the needs of the target population. Case-finding will be multi-directional, with referrals coming from each "sector" - navigator-coaches, ER, case management and primary care – to the appropriate resources for follow-up, activation and management. As navigators identify and assess UI, LU and NU individuals on the PAM scale, the approach and appropriate level of follow-up will be determined. Navigators-coaches will ensure that those individuals who score at the higher levels of activation (3 or 4) will have or be linked to a PCP. Those who score at 1 or 2 will continue with peer coaching and be linked to case management and primary care. For individuals without PCPs, they will be linked with primary care resources based on geography, cultural match, and financial accessibility. Navigators-coaches and PCP staff will reassess individuals using PAM on a semi-annual basis to determine changes in activation and engagement. If PCPs identify individuals in need of case management and/or coaching, referral to the appropriate resource will be made. Oversight of the project will remain with the PAC Executive Committee to ensure that coordination continues across the entire system.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The difficulty of activating and engaging the UI, LU and NU populations cannot be underestimated. It will require extensive coordination and communication across the system, dedication to all aspects of "case-finding", assessment, triage and case management, and ensuring that financially accessible primary care is available across the county.Case-finding: Navigator-coaches will be recruited from and deployed to sites in hot-spots. They will be trained in outreach and PAM, and will have educational materials that are designed to address and improve health literacy. Additionally, all PPS partners will be engaged in identifying UI, LU and NU individuals, and linking them to navigators and/or case managers. Assessment/triage: Navigator-coaches, case managers and primary care staff will be trained in the use of PAM and the appropriate follow-up for individuals based on their PAM score. Case management: Current case management is siloed at the hospitals, CBOs and other PPS partners. Creating an overarching case management infrastructure will better equip the PPS to ensure such services are provided in an integrated fashion to individuals regardless of where they "touch" the system, and that resources are deployed to the venues where they are most needed.

Additionally, there is a need to engage the MCOS to ensure that services are coordinated and duplication eliminated.Financially accessible PCPs: The PPS will need to engage PCPs across the county. Where gaps exist, the PPS will need to recruit practitioners and place them in those communities. This will be done collaboratively with clinics, health centers and existing practices.Communication: To ensure that communication is maximized across the system, all partners will be linked electronically. Regular meetings among CBOs, PCPs and case management will occur.MCO collaboration: To date, MCO responsiveness to project engagement has been limited. Efforts to address this will be a high priority during implementation planning.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

There is no other PPS within the service area.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Tablets for outreach workers

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Outreach Development Corp	Health Home			Care Management
Suffolk County DOH	NYSDOH Maternal Infant Community Health Collaaborative	10/1/13	9/30/18	Using CHWs to target high risk women of childbearing age
The Sayville Project	Health Home			Care Management
The Sayville Project	SC Discharge Planning Care Coordination Initiative			Improve Care Coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the

attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.