Suffolk Care
Collaborative

Consolidated Project Information

Project 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

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2.d.i Project Objective & Requirements

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.

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

The project must clearly demonstrate the following 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.

2.d.i Requirements Matrix by Provider Type

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
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.									X
2) Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.									X
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.									X
4) Survey the targeted population about healthcare needs in the PPS' region.									X

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
5) Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.									X
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									X
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.									X

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
8) Include beneficiaries in development team to promote preventive care.									X
9) Measure specific PAM® components									X
10) Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.									X
11) Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage community healthcare resources (including for primary and preventive services) and patient education.	X	X	X	X	X	X	X	X	
12) Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.									X

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
13) Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.	X	X	X	X	X	X	X	X	
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 healthcare services and resources.	X	X	X	X	X	X	X	X	
15) Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.									X
16) Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services									X

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
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									X

2.d.i Milestones & Metrics

Color Legend
Project System Changes
Project Requirements with Specific Time Periods
Project Requirements tied to PPS Speed and Scale Commitments

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
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.	Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.	MOUs, contracts, letters of agreement or other partnership documentation; Quarterly reports demonstrating successful implementation of project requirements	Project
2	Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.	Patient Activation Measure® (PAM®) training team established.	Description of the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy training agenda materials, and team staff roles who will be engaged in patient activation	Project
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.	Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	"Hot spot" map delineated by UI, NU, LU types; Evidence of CBO outreach within appropriate "hot spot" areas; Outreach lists for UI, NU, and LU populations	Project
4	Survey the targeted population about healthcare needs in the PPS' region.	Community engagement forums and other information-gathering mechanisms established and performed.	List of community forums held, detailing locations, agenda, and presenters; Documentation surveys or other information gathering	Project

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
			techniques	
5	Train providers located within “hot spots” on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM® trainers".	List of PPS providers trained in PAM®; Training dates; Written training materials	Project
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.	Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.	Documented procedures and protocols; Information-exchange agreements between PPS and MCO	Project
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.	For each PAM® activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	Baseline, periodic and annual PAM® cohort reports and presentations	

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
8	Include beneficiaries in development team to promote preventive care.	Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	List of contributing patient members participating program development and awareness efforts	Project
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's 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.	Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM® survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis Annual report assessing individual member and the overall cohort's level of engagement	Performance measurement reports and presentations; Annual reports; Member engagement lists, by PAM® cohort	Project

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
10	Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Volume of non-emergent visits, for UI, NU, and LU populations, increased.	Baseline non-emergent volume with periodic reports demonstrating increase in visits (specific to UI, NU, and LU patients)	Project
11	Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage community healthcare resources (including for primary and preventive services) and patient education.	Community navigators identified and contracted.	Periodic list of community navigator credentials (by designated area), detailing navigator names, location, and contact information	Provider (PAM providers, CBOs)
		Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	List of training dates along with number of staff trained; Written training materials	Provider (PAM providers, CBOs)
12	Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Policies and procedures for customer service complaints and appeals developed.	Documented procedures and protocols	Project
13	Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.	List of community navigators formally trained in the PAM®.	Description including the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy of training agenda materials, and team staff roles who will be engaged in patient activation	Provider (PAM providers, CBOs)

	Project Requirement	Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
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 healthcare services and resources.	Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	Evidence of navigator placement by location	Provider (PAM providers, CBOs)
15	Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Navigators educated about insurance options and healthcare resources available to populations in this project.	List of navigators trained by PPS; Names of PPS trainers; Training dates; Written training materials	Project
16	Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Timely access for navigator when connecting members to services.	Policies and procedures for intake and/or scheduling staff to receive navigator calls; List of provider intake staff trained by PPS	Project
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.	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Sample patient registries; EHR completeness reports (necessary data fields sufficiently accurate to conduct population health management)	Project

2.d.i Active Engagement Definition

The active engagement definition for project 2.d.i is defined as the number of individuals who completed PAM® or other patient engagement techniques.

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
2.d.i	45,426	262,312	31%	Individuals who completed PAM	3

The purpose of counting methods is to estimate the number of patients that will be impacted by a particular project. This feeds the patient scale portion of the application.

Each counting method should be used in conjunction with the definition of "actively engaged" patients for that project.

Summary of counting method 3:

- Counted within a DSRIP year; resets each year
- Patients are to be counted only once
- So long as "at least" one encounter with the patient resulted in A.E. definition being met, it counts towards total

e.g., if a patient visits the PCP 5 times a year but get a1C tested just one of those 5 times, she is actively engaged

2.d.i Speed and Scale Submission

Scale is a measure of the magnitude of providers in the project and the volume of patients affected. Speed is a measure of how quickly project requirements are executed and how quickly patient impact occur. Speed and Scale represent 80% of the points for each project application – and therefore, most significantly impact initial valuation.

Project Implementation Speed for Project 2.d.i

Project	DY 0 (2014)		DY 1 (2015)		DY 2 (2016)		DY 3 (2017)		DY 4 (2018)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
2.d.i									X	

Patient Engagement Speed for Project 2.d.i

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	4542	11356	9085	22712	15899	34069	22712	45426
Expected # of Actively Engaged Patients	45426	45426	45426	45426	45426	45426	45426	45426	45426	45426

Rationale for Project 2.d.i

The rationale related to project 2.d.i implementation speed is as follows:

- Project Implementation will meet all project requirements in quarters 1 and 2 of DSRIP Year 4.

The rationale related to project 2.d.i patient engagement speed is as follows:

- For this project, the definition of actively engaged is the number of individuals who completed PAM® or other patient engagement techniques.
- Patients are counted as those who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.

The patient scale rationale is calculated as detailed below.

Patient Scale Rationale			
	Uninsured Population		Non-Utilizer + Low-Utilizer Population
Baseline # of Patients	168,618 Patients	**Baseline # of Patients**	93,694 Patients
10% Expected Engagement Factor	16,861 Patients	**30% Expected Engagement Factor**	28,564 Patients
Total	16,861 Patients	**Total**	28,564 Patients
	Expected # of Actively Engaged Patients	=	**45,426 Patients**

References

Please see pages 38-46 in the Suffolk Care Collaborative DOH Application for additional project related information.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf