Project 2.d.i Implementation of Patient Activation Activities

Project Goal: Address Patient Activation Measures ("PAM") so that uninsured, non-utilizing, or low utilizing populations are impacted by DSRIP projects. This project is centered around patient activation and engagement, health literacy, and practices to reduce health care disparities.

Actively Engaged

Actively Engaged Definition	*The number of individuals who completed PAM® or other patient engagement techniques.*
Counting Criteria	A count of patients 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.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Currently PAM® is the only activation measure being considered for implementation in this project.
- If additional patient engagement techniques are utilized they must be evidence-based and/or peer reviewed, demonstrating that they are patient activation techniques that are equal to or better than PAM®.
- PAM® surveys completed by parents/guardians on behalf of younger patients would count for active engagement.

Quality Measures

Measure Name	Numerator	Denominator
PAM Level	Interval measure of % of members of total with Level 3 or 4 on PAM	Baseline measure of % of members of total with Level 3 or 4 on PAM
Use of primary and preventative care services-Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU and LU Medicaid Members)	Measurement year percent of NU and LU Medicaid members who do not have at least one claim with a preventive services CPT or equivalent code.	Baseline percent of NU and LU Medicaid members who do not have at least one claim with a preventative services CPT or equivalent code
ED use by uninsured	Annual measure of # Emergency Medicaid ED visits/1000 Emergency Medicaid Recipients	Baseline measure of # Emergency Medicaid ED visits/1000 Emergency Medicaid Recipients
C&G CAHPS by PPS for uninsured	Using the C&G Visit Survey, Annual measure of four composite measures.	Using the C&G Visit Survey, Baseline measure for four composite measures: 1) Getting timely appointments, care, and information (5 items)

Project Requirements & Metrics/Deliverables

Project Requirement		Metric/Deliverable	Due Date
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.	3/31/17
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.	3/31/17
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.	3/31/17
4	Survey the targeted population about healthcare needs in the PPS' region.	Community engagement forums and other information-gathering mechanisms established and performed.	3/31/17
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".	3/31/17
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.	3/31/17
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).	3/31/17
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.	3/31/17
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	3/31/17
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.	3/31/17
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. Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	3/31/17
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.	3/31/17
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®.	3/31/17
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.	3/31/17
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.	3/31/17
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.	3/31/17
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.	3/31/17