

**WMC DSRIP PPS Project Plans**

**Application Section 4**

*Submitted December 22 2014*

**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**

**Project Response & Evaluation:**

**1. Project Description and Justification**

**1a. 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 should consider three primary activation concepts: *patient activation, financially accessible health care resources, and partnerships with primary and preventive care services.***

Our Patient Activation Project will address the need to engage and activate the uninsured (UI) and Low Utilizing (LU) and Non-Utilizing (NU) Medicaid populations and increase access to and effective utilization of healthcare resources. Though the rate of uninsured in the broader region (11.7%) is lower relative to the State (12.6%), rates vary significantly by county from 9.4% in Putnam County to 13.9% in Sullivan County.

The distribution of uninsured varies by race and age. In Sullivan for example, approximately 13% of White and 13% of Black residents lack some form of health insurance. Within the 18-24 year-old population roughly 38% of White and 32% of Black young adults are uninsured. Among individuals of Hispanic/Latino origins the percentage of uninsured is much higher, 42.5% overall. There is also a significant increase within this group once an individual turns 18 years old, with 9.1% uninsured between the ages of 6-17 and that rises to a 87.3% uninsured within the 18-24 year age group.

As part of our CNA, we distributed a consumer survey and received 4,777 responses. Among the Medicaid and uninsured respondents, who represented 31% and 10% respectively of our respondents, Medicaid beneficiaries were almost twice as likely and uninsured individuals were 1.2 times as likely to have been to the ED in the past 12 months for care compared to commercially insured respondents. Among reasons indicated for the visit, almost 13% of uninsured respondents indicated that there was "no other place to go."

Among those surveyed, areas of lowest utilization of key prevention services were found in Orange County, where 83.1% of adults had a regular health care provider, and 86.7% of adults have had a routine check-up in the past two years.

With respect to knowledge and utilization of the health system, focus groups of Medicaid, uninsured and insured consumers revealed that most patients do not have a case worker, social worker, or advocate helping them navigate the system. Participants indicated that an accessible, understandable, and centralized resource was not available, or if there was one, none of the participants were aware of it.

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To improve patient activation, our PPS will hire field managers for each of four geographic Hubs in our region: Westchester/Putnam, Dutchess/eastern Ulster, western Ulster/Sullivan/Delaware, and Rockland/Orange. We will recruit candidates with demonstrated bilingual and cultural competence skills and experience working with local community-based organizations (CBOs). Field managers will comprise a PPS-wide training team to provide ongoing oversight and supervision to the local CBOs around project objectives and deliverables. Field managers will oversee recruitment and training of community navigators. CBOs will be selected for participation based on location near or within “hot spots” where UI/NU/LU populations seek services.

To ensure that community members access a system that has “no wrong door,” we will create a virtual “Outreach Cooperative” within each Hub that provides: training to existing community outreach workers on patient activation using the 13 question Patient Activation Measure (PAM), shared decision making, health literacy, and cultural competency.

Community members will be able to receive patient activation coaching; learn about appropriate use of healthcare services and affordable community healthcare options; receive assistance making appointments for primary, behavioral health and dental care; and be connected with their health plan and PCP if they have one, or referred to a Marketplace Facilitated Enroller for help with insurance options.

**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 Medicaid member populations will be attributed to this project.**

Our PPS will focus on the UI, LU and NU Medicaid populations and work to engage and activate individuals to utilize primary and preventive care services. To improve patient activation, we will pursue a two pronged strategy: (1) leverage the resources of organizations that work with LU and NU Medicaid members and the UI, and (2) develop a core capability to coordinate, train, and conduct patient activation activities across the region.

To better understand where community challenges are most prevalent, we utilized hot spotting techniques developed by Dr. Brenner of the Camden Coalition. We identified “hot spots” zip codes with higher disease prevalence and/or under representation on key prevention measures. We identified the top 9 high-density zip codes in our region: Mt. Vernon (10550), Yonkers (10701 and 10705), Kingston (12401), Newburgh (12550), Middletown (10940), Poughkeepsie (12601), New Rochelle (10801), and Spring Valley (10977). Survey respondents from the hot spot zip codes represent 25% of our consumer survey respondents. Respondents in hot spots were more likely to have visited the ED in the past year for care due to access

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issues. These communities also present with higher rates of asthma and smoking and lower rates of cancer screenings. We will target the patient population within the identified hot spots and recruit CBOs within each area.

In our region, the LU, NU and UI currently engage the health system at multiple points, including FQHCs, EDs, Medicaid MCOs, and organizations that facilitate insurance enrollment. FQHC staff will be trained on use of the PAM. Our PPS will work with FQHCs to ensure patients screened with PAM are entered into the PPS registry to track the PAM scores at baseline and for each year's cohort of patients per the method to be established by NY State. As providers of primary care services, FQHCs will be well positioned to deliver patient activation coaching to patients who initially screen low with a goal of identifying and closing gaps in care and moving the patient to a higher level of activation. We will also work with our 14 hospitals to incorporate patient activation information and surveys in EDs.

**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 11<sup>th</sup> 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.**

Our PPS formation included the creation of a robust network of over 275 CBOs in our Community Resource Database that serve a wide spectrum of social service needs. We will enable this database to be patient facing and link it to a searchable tool that assists patients and families locate needed services. The relationships that we have initiated through the CNA process with housing activists, food banks and regional perinatal networks will form the basis our outreach to the UI, NU, and LU populations.

Our PPS also includes one of the largest NY State of Health Insurance Navigator Agencies in our region, the Maternal Infant Services Network (MISN), which has eight Marketplace Facilitated Enrollers and three subcontracted agencies. We will work with MISN and other organizations' Facilitated Enrollers to incorporate patient activation programs into their existing enrollment outreach efforts.

For the uninsured, MCOs also serve as potential points of engagement. In our region, the three largest MCOs (Affinity, Fidelis, and MVP) have representatives who assist uninsured individuals obtain coverage. The health plans' field representatives, formerly called Certified Application Counselors, often encounter people who are not eligible for insurance. We will work with MCOs to augment their enrollment efforts to include strategies and pathways to improve the UI's patient activation. We will also work closely with MCOs to identify and engage the LU and NU Medicaid beneficiaries. We will obtain lists of PCPs assigned to NU and LU enrollees from MCOs to help them reconnect with their designated PCP. In concert with MCOs and PCPs (and with approval from NYS), we will develop material for outreach to LU and NU Medicaid beneficiaries

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to encourage them to connect or re-connect with their PCPs. Outreach materials will include language on how to file a complaint and receive customer service. To increase the likelihood that prevention strategies are adopted by the target populations, we will include representatives from the UI, NU, and LU populations in the team that develops and promotes preventive care.

Staff at participating FQHCs, PCPs, and EDs will be trained to collect updated contact information during PAM screening, and we will notify MCOs on a monthly basis of any formerly NU and LU members who are engaged through this project. All three project cohorts (UI, NU, LU) will be surveyed using PAM<sup>®</sup> during the first year of the project and at annual intervals throughout the project.

We will 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. If the patient is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, we assess the patient using PAM<sup>®</sup> survey and designate a PAM<sup>®</sup> score. We will track the UI cohort over the entirety of the DSRIP program.

In support of partner organizations in the Hubs, our PPS is developing a centralized service infrastructure that will: (1) maintain a core competency on patient activation techniques; (2) facilitate region-wide coordination; (3) develop and deploy standardized training modules, patient assessment tools, and best practices and strategies to improve patients' activation levels; (4) identify and track patients and program progress through a centralized electronic system that includes (within the limits of confidentiality laws) a master index of contacted individuals; (5) perform population health management by actively using EHRs and other IT platforms; (6) support the increased provision of non-emergent care; and (7) establish and maintain a capacity to take complaints and provide customer service.

**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 barrier to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.**

We anticipate challenges (1) locating patients, (2) cost-effectively implementing surveys, (3) improving patient activation scores and utilization of primary and prevention services, and (4) obtaining informed consent.

Locating the target population, most of whom lack consistent contact with clinical settings, represents a significant challenge. To meet patients "where they are," we will conduct outreach at multiple points including CBOs, FQHCs, EDs, and organizations that facilitate insurance

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enrollment to ensure direct and timely hand-offs to navigators who facilitate age-appropriate primary and preventive healthcare services and resources. We will collect centrally and rapidly diffuse lessons learned, engagement best practices, and up-to-date information on insurance options and healthcare resources.

Administering patient activation surveys represents a new and significant responsibility for our PPS partners. We will use Plan-Do-Study-Act cycles to help incorporate PAM screening into our partners' workflows. We will provide payment incentives to organizations based on the number of survey instruments completed. To increase the likelihood of patients' completion of activation assessments, we may offer a free mobile phone application that links patients with local clinical and social services.

Locating and assessing the target population represent important first steps, but will not guarantee improved activation scores and health outcomes. Consistent and sustained engagement with the health system results from a foundation of patient understanding and trust. To establish trust and rapport, we will partner with CBOs and others to recruit community members to serve as peer and community navigators to promote connectivity with the healthcare system and assist with patient activation and education. Our patient activation outreach and engagement strategies will include provisions for culturally competent community navigators who are trained in patient activation techniques and education for the target age ranges. Once engaged, we will link patients to services that support the full range of clinical and social service needs.

Tracking PAM scores for individuals who are encountered in a CBO location may require an Institutional Review Board process and elaborate consent that could be an obstacle to wide engagement. We will work with NYS to address this concern.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across the region and New York State. The three PPSs serving the region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, including input from providers, payers, government agencies, and others, will review DSRIP project plans and implementation and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar

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expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and its payers.

Although the other two PPSs in our region are not implementing project 2.d.i., we will work with them to facilitate the identification of the uninsured population, provide updates on engagement and enrollment progress, and share best practices on patient activation efforts.

Beyond our region, we will share best practices and lessons learned with the other PPSs that are implementing project 2.d.i. statewide.

## **2. Scale of Implementation**

*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:*

**2a. Please indicate the total number of individuals trained in PAM or other patient activation techniques the PPS intends to include in the project by the end of Demonstration Year (DY) 4, or sooner as applicable. These numbers should be entered in the table as Total Committed.**

***See accompanying Speed & Scale Excel document***

**b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the Expected # of Actively Engaged Patients. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.**

***See accompanying Speed & Scale Excel document***

## **3. Speed of Implementation/Patient Engagement**

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*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 foals. 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:*

**3a. Please indicate the Demonstration Year (DY) and Quarter by which all participating individuals trained in PAM or other patient activation techniques will achieve project requirements. pProject speed is measured by how fast all the project requirements for all chosen locations are met.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS “total committed” scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

***See accompanying Speed & Scale Excel document***

**b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of targeted patients will be actively engaged by the end of Demonstration year 1, 50% by the end of Demonstration year 2, etc.**

***See accompanying Speed & Scale Excel document***

**4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)**

**4a. Will this project require Capital Budget funding? (Please mark the appropriate box below)**

Yes	No
X	

**Please describe why capital funding is necessary for the Project to be successful.**

Our PPS will need capital funds to provide meeting space to train staff to use the PAM survey instrument. Electronic tools, such as computers and tablets, will be critical tools to help the PPS effectively screening patients using the PAM survey, collect patient information, and record

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PAM scores. Capital funds will also be used to pay for licenses for educational software and online modules to advance patient health literacy.

The Westchester-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for patient outreach, engagement, and activation activities. The capability will be shared across all 11 DSRIP projects and are central to our IDS development.

**4b. 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
X	

**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.**

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Family Service Society of Yonkers	NYS DOH Senior Supportive Housing Services Program	2014	2016	The Senior Supportive Housing Services Program combines capital assistance and supportive services within existing senior housing communities to serve low-income, Medicaid eligible seniors who are homeless or reside in the community and who are at risk of nursing home placement and seniors transitioning out of nursing homes into community living who require long term care services.

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The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
The Greater Hudson Valley Family Health Center, Inc.	Partnerships for Care HIV grant (CDC & HRSA)	9/1/14	8/31/17	The Partnerships for Care HIV grant supports the identification of undiagnosed HIV infection, establishes new access points for HIV care and treatment, and improves HIV outcomes along the continuum of care for people living with HIV (PLWH). Funding supports required staffing and equipment.
The Greater Hudson Valley Family Health Center, Inc.	Outreach and Enrollment (HRSA)	6/1/13	Ongoing	Supports navigation assistance to patients using New York's Marketplace, New York State of Health.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying

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				condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

**4c. 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.**

This project will seek to connect low utilizing, non-utilizing Medicaid members, as well as the uninsured, to health care services. It will not supplant funds currently supporting existing services but rather will use the relationships set in place through these programs to reach uninsured members of the target population. For example, through the foundation set in place by the Senior Supportive Housing Services Program, our PPS will aim to reach uninsured seniors and, to the extent applicable, other uninsured members of the target population. The project will expand the impact of this program and the services of health centers, by connecting the target population identified through these programs with a full range of social supports and medical services. Further, the project will expand, not supplant, outreach and enrollment assistance funding to reach greater numbers of uninsured New Yorkers eligible for marketplace or Medicaid coverage.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a larger group of low/non-

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utilizing Medicaid patients who are not currently eligible for Health Home services, and will expand the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.