The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program is to restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. In partnership with hospitals, public health agencies, physicians and community-based organizations, the North Country Initiative is advancing state-wide projects to transform the healthcare system, coordinate care, and improve the health and wellness for our population.

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Implementation of Patient Activation to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

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.

Project Description:

This project is focused on persons not utilizing the healthcare 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 baselining 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 healthcare resources
- Partnerships with primary and preventive care services

Patient Population:

The uninsured, non-utilizers and low-utilizing Medicaid patients or recipients

Identified Community Need:

Often times the only contact that the uninsured and Medicaid non utilizers/low utilizers have with the healthcare system is through the emergency department or an acute care hospitalization. Engaging this population in the healthcare system can prevent future emergency department and inpatient utilization and prevent future onset of chronic disease

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Project Milestones

1	Contract or partner with community-based organizations (CBO's) 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 CBO's to perform outreach in identified "hot spot" areas.
4	Survey 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. During the first demonstration year determine the baseline for each beneficiary. Baselines, as well as intervals toward improvement must be set for each cohort at the beginning of each performance period.
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(R) 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.
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 healthcare 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 healthcare 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.