



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. Project Justification, Assets, Challenges, and Needed Resources (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*.

According to the CNA, there are approximately 1.3 million uninsured (UI) residents in our PPS service area, with the greatest number residing in Queens and the fewest in Manhattan. In addition, the State attributed 694,685 non-utilizers (NUs) low-utilizers (LUs) in the PPS and 1,141,563 uninsured to our PPS (based on December 13, 2014 DSRIP performance attribution results). The CNA estimated that nearly 21% of all individuals in our service area live below 100% of the FPL, 18.6% are non-US citizens, 22% of adults have less than a high school graduation, and 24.6% speak English “less than well” (CNA need 3). These rates exceed NYC and NYS averages and have been shown to be associated with disconnectedness from the health care system.

This project will be implemented to close CNA-identified gaps and to improve the outcomes of UI and LU/NU Medicaid beneficiaries in our service area (CNA need 1). Our approach will: activate patients by leveraging existing provider and community-based staff, including health plan partners (e.g., MetroPlus), to improve patient engagement as measured by PAM or another instrument; strengthen existing and develop new partnerships with entities providing primary care and preventive services and increase use of these services (CNA need 2); identify the range of available services that are financially accessible and educate our population about their availability; reduce inappropriate use of inpatient and emergency services (CNA need 1); and, improve Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.

To achieve these goals, our PPS will employ a multi-pronged approach including: outreach and patient



identification; eligibility determination for and enrollment in healthcare coverage; and, patient activation, patient education, and linkages to care for all patients, regardless of insurance status.

For outreach and patient identification, our PPS will leverage internal resources (e.g., hospital ED data and hospital-based application counselors) and contract with CBOs to provide outreach and assistance. CBOs will undertake focused activities to identify LU/NU patients. We will work with NYS-designated Navigators and other organizations with expertise in providing culturally responsive services and ensuring patients understand available financially accessible resources. In addition, our PPS will coordinate outreach with NYC agency partners including, but not limited to, the NYC Department of Health and Mental Hygiene (DOHMH) and the NYC Human Resources Administration (HRA). Finally, we expect to leverage patient assistance and managed care resources, including those offered through MCOs (e.g., MetroPlus, HealthFirst).

For eligibility determination and enrollment in coverage, we will contract with CBOs and leverage MCO partners to educate and assist patients. This will include the use of MCO-maintained lists which identify PCPs assigned to NU/LU enrollees. We will then conduct outreach to reconnect beneficiaries to their PCP. This may include the use of telephonically-based health coaches and proactive work with respective MCOs and PCPs. We will also continue work with the Mayor's task force on immigrant healthcare formed in late 2014.

Once identified, we will connect patients to services (e.g., clinical, care management, care coordination) and provider linkages to social services and supports in order to provide whole-person care (CNA needs 1 - 5). Programs may include PCMH, Health Home, or other relevant programs or services. Enrolling patients in these care models is the most direct path to improve patient engagement and to ensure that patients access the right care at the right place and time. Expanding and enhancing our PPS's primary care footprint through project 2.a.i (e.g., increased staffing, increased hours at existing facilities, and contracting for primary care services) will be an essential component to ensure adequate access to care for all PPS beneficiaries (CNA need 2).

- 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.

We expect to engage uninsured, LU or NU individuals. Our State-determined portion of LU/NU individuals is 694,685 and our State-determined portion of uninsured individuals is 1,141,563. This results in a total interim attribution for this project of 1,836,248. These data reflect December 13, 2014 DSRIP performance attribution results.

Our PPS will initially focus on those with chronic illness, immigrants, those with limited English proficiency, and the undocumented, as these groups have been shown to have lower insurance rates and irregular contact with the healthcare system (CNA needs 1, 3). As we engage these population



groups, our PPS will expand our reach to a population.

In addition, we expect to collaborate closely with two emerging citywide initiatives to address the needs of undocumented immigrants and those recently released from incarceration. By linking our efforts in this project to other related efforts to engage hard-to-reach patients and families, we expect to meaningfully impact the rates of inappropriate hospitalization and ED visits, the quality of care provided, and ultimately, the health of our communities.

- 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.

Our PPS has a range of assets and resources that we will use to implement this project. HHC's work on Staten Island Health Access (SIHA) provided valuable learnings on how to effectively engage CBOs through contracts to conduct community outreach and enrollment and help enrollees access needed care. One MCO in our PPS, MetroPlus, has expertise gained through its CBO-related contracting work via its HIV Special Needs Plan. HHC has a Consumer Assistance Program (CAP) for which we closely coordinate with community providers, with an emphasis on coordination with behavioral health providers.

For outreach and identification, our PPS will partner and contract with CBOs to identify uninsured, LU and NU hotspots and to provide outreach in their respective communities. For the uninsured population, CBOs will link patients to insurance enrollment and financial assistance resources, as well as connect patients to PCPs. For LUs/NUs, our PPS will work in partnership with Medicaid MCOs to re-connect patients to their PCPs.

For eligibility determination and enrollment, our PPS has a minimum of 775 certified application counselors (CACs), including 570 at HHC, 200 at MetroPlus, and 5 at SUNY, with more to be trained in 2015. In addition, there are 120 managed care staff. All will be trained in PAM or another activation tool.

CACs located within PPS facilities will help uninsured patients apply for Medicaid or other health insurance through the Health Insurance Marketplace (New York State of Health) or HRA if they are uninsured. They will also help patients apply for charity care if they are ineligible for insurance or are underinsured. The PPS will arrange CAC training for CBO partners through MetroPlus on an as-needed basis. The PPS will also make educational materials and trainings available to partners with regard to relevant programs and services (e.g., HHC's charity care program, HHC Options, financially accessible health care resources) and will emphasize the importance of ensuring coverage and access.

For patient activation activities and linkage to care, the PPS will seek to educate insured patients as to approaches to more effectively use their coverage (e.g., making appointments with their PCP, access to other services, etc.). Many of our partners have considerable experience engaging and addressing the unique needs of the target population. For example, the HHC delivery system has deep and long-standing relationships with CBOs focused on the target population, and as referenced above, MCO partners also have deep and longstanding relationships into the target communities. Our PPS intends to



leverage these relationships, as well as work with our CABs and project advisory committee (PAC) to develop and implement creative strategies to seek out and engage the target population.

Based on our extensive experience partnering with CBOs, we will establish infrastructure to support the ability of CBOs to refer patients directly to appropriate physical or behavioral health providers. Managed care staff will educate patients on the use of their health plans, including member services, PCP assignment and authorizations. Our PPS expects to support partner CBOs to expand their capacity to ensure that we have the appropriate staff levels and expertise to find and engage the target population, consistent with implementation scale and speed estimates.

- 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.

Our PPS anticipates a number project challenges. First, we must find, identify and connect with the uninsured population, including the undocumented and those without formal connection to the healthcare system. To address this challenge, we will work with partners that have culturally-responsive approaches and engage trusted community leaders. We will also coordinate with CBOs that have existing relationships to the community and outreach expertise. We expect to target neighborhoods identified in the CNA as having high rates of uninsured.

Second, we anticipate challenges to overcome cultural barriers for new immigrants, some of whom have not had contact with a formal healthcare system. Enhancing CBO relationships will help build bridges to these communities. Activities may include, but will not be limited to, providing training support and establishing linkages to the PPS care management systems and MCO relationships. The use of community health workers and peer educators will also support outreach and engagement efforts.

Third, we expect there to be affordability concerns related to coverage and access. To address this barrier we will seek to provide education about various programs offered by some of our partners to provide a range of free and low-cost services, including HHC's Options program. In addition, our PPS may seek state regulatory relief on co-pay collection requirements.

Fourth, we believe that barriers may exist to implementation of a consistent approach to the use of PAM or other activation tool. Because consistency across the PPS is essential, we will work within our PPS and across NYC to identify options to standardize roles, qualifications and training as needed.

Fifth, we anticipate that improving health literacy will be challenging. To address this, we will develop "plain language" materials that meet commonly-accepted health literacy standards.

Finally, the complexity of our healthcare system and the diverse needs of patients will prove challenging. This complexity is evidenced by our broad patient base which has a variety of physical and behavioral health needs and is complicated by many risk factors related to the social determinants of health (e.g., lack of stable housing, food insecurity, relationship to the criminal justice system).



- 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.

As part of planning activities to date, our PPS has collaborated with Bronx Partners for Healthy Communities (BPHC) and Community Care of Brooklyn (CCB). We have achieved a number of important goals, including aligning project selection and identifying areas for future collaboration.

With regard to Project 2.d.i, we expect to coordinate with other NYC-based PPSs to address hot spot identification, training on coverage options and financial assistance (charity care) resources, and ensure that other PPSs have robust mechanisms and pathways to help patients ineligible for insurance. We will also work with other NYC PPSs in our service area to identify additional capacity, as needed, to support Project 2.d.i implementation activities.

In addition, we will develop mechanisms to ensure that NU/LU patients who have existing relationships with providers, who may be part of another PPS, are directed in a timely manner to their “home” provider and health system. We expect to target neighborhoods identified in the CNA as having high rates of uninsured, and to collaborate with other PPSs and city agencies to further coordinate outreach. As part of our citywide role to implement this project, we intend to convene the PPSs as well as relevant city agencies on a regular basis.

2. Scale of Implementation (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. Speed of Implementation/Patient Engagement (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. Project Resource Needs and Other Initiatives (Not Scored)



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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

This project will require capital funding. This funding is necessary to purchase mobile devices to assist with engaging patients in the community and in certain “hot spots” such as emergency rooms. Mobile devices will allow navigators to provide on-the-go outreach and education.

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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.



New York Department of Health
 Delivery System Reform Incentive Payment (DSRIP) Program
 Project Plan Application

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
AIDS Service Center of Lower Manhattan, Inc.(ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
AIDS Service Center of Lower Manhattan, Inc.(ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
Arab American Family Support Center	New York State of Health	August 2013	September 2018	Arab American Family Support Center provides in-person enrollment assistance.
Bronxworks	New York State of Health	August 2013	September 2018	Bronxworks provides in-person enrollment assistance.
Brooklyn Alliance	New York State of Health	August 2013	September 2018	Brooklyn Alliance provides in-person enrollment assistance.



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Brooklyn Perinatal Network	New York State of Health	August 2013	September 2018	Brooklyn Perinatal Network provides in-person enrollment assistance.
CACF	New York State of Health	August 2013	September 2018	CACF provides in-person enrollment assistance.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to between 300 – 900 members per month.
Community Service Society	New York State of Health	August 2013	September 2018	Community Service Society provides in-person enrollment assistance.
Hispanic Federation	New York State of Health	August 2013	September 2018	The Hispanic Federation provides in-person enrollment assistance.



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Joseph P Addabbo Family Health Center	New York State of Health	August 2013	September 2018	The Joseph Addabbo Center provides in-person enrollment assistance.
NADAP	New York State of Health	August 2013	September 2018	NADAP provides in-person enrollment assistance.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

- 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.

Project 2.d.i expands on enrollment activities currently performed by Navigators under the NY State of Health (NY's state-based marketplace) by working with individuals after they have obtained health insurance. This ensures that current uninsured do not become future low- or non-utilizers. Project 2.d.i will follow the patient from uninsured status through their first visit and beyond. Project 2.d.i will also build on care management work being done by partners through Health Home programs to help low-and non-utilizing Medicaid population engage in their care. Work related to 2.d.i is not duplicative of these other programs in that 2.d.i activities are focused on those who are not already engaged in regular care.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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.