Suffolk Care Collaborative
Community Health Activation Program (CHAP)

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 Charter

Executive Summary:

This project is focused on persons who are uninsured or under- or not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care. Through evidence-based patient activation activities, the PPS will identify those individuals and measure and improve their health literacy and level of activation, thereby encouraging active management of their personal health.

Objective Statement:

The Suffolk Care Collaborative (SCC) will implement patient activation activities across Suffolk County in the uninsured (UI) and low-utilizing (LU) and non-utilizing (NU) Medicaid populations, through cooperation and interaction with CBOs and health care providers, and managed care organizations, in order to engage them to seek primary and preventive care services.

Target Population:

With a population of 1.5 million, Suffolk County has approximately 240,000 Medicaid members and 168,618 uninsured. It is reported that about 29% of Medicaid recipients are NU or LU. This equates to 69,381 for the PPS, bringing the total target population to 237,999.

For the purposes of this project, primary efforts to activate and engage patients will be targeted to four communities, Riverhead/Hampton Bays, Brentwood/Bay Shore/Central Islip, Huntington Station and Patchogue, where the majority of uninsured and Medicaid recipients reside. Through our network of participating CBOs navigators will identify, assess and triage individuals to case managers and PCPs based on their level of activation as measured by the PAM® scale.

For more information on the target population of our project, please refer to page 41, Section 1b, of the attached DOH Project Plan Application found at the following web address:

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

High Level Deliverables:

- **Patient Activation (PA):** Develop activities that promote community activation and engagement
    - Identify target locations; Establish team of Patient Activation Measure (PAM®) experts; Train key community stakeholders in PAM®, including providers, Hospital staff, CBOs, Care Navigators, etc.; Work with MCOs to define Non-utilizer and Low-utilizer Medicaid members; Measure and intervene with defined cohort; Track cohort over 5 year project period
- **Linkages to Financially Accessible Health Care Resources:** Provide community bridges that allow access to health coverage resources
    - Promote and Navigate access to primary, behavioral and dental care for uninsured and newly activated Low-utilizing Medicaid beneficiaries.
- **Linkages to Health Systems and PPS:** Build linkages to community based primary and preventive services and community based health education to grow community and patient activation across the county.
    - Develop community Navigators (in collaboration with CBOs), train Navigators in PAM®; place Navigators in community settings; Ensure insurance enrollment, where applicable; Ensure access to care.

Benefits:

- Higher levels of health care engagement of PPS patients
- Sustainable health care, CBO partnerships to create extended linkages to care for patients
- Increase in workforce expertise (PAM® administration, Patient Activation (PA) techniques, cultural competency training)
- Best practice models of patient activation in various populations in Suffolk County

Assumptions:

Simply having health insurance is not enough to ensure improved health outcomes or appropriate use of the health system. A lack of familiarity with that system, coupled with social and cultural barriers to care, results in avoidable utilization of high-cost health care resources among some uninsured (UI), and/or low- and non-utilizing Medicaid recipients (LU/NU).

The Community Needs Assessment (CNA) documented barriers to access among uninsured and Medicaid recipients. By comparing Medicaid and uninsured respondents to county-wide findings, significant disparities became evident. These populations have

difficulty accessing healthcare because of the cost of physician visits and prescriptions; inconvenient office hours/appointment availability; difficulties finding physicians; and lack of transportation. Additionally, both cultural and linguistic barriers exist for many. These individuals experience greater levels of mental health problems and childhood obesity, and report a lack of leisure time. They are also more likely to skip/stretch prescription doses, use the ER and have difficulty getting care for their children. In regard to ER usage, Medicaid members had 119,932 total visits, of which 72% were potentially avoidable. Comparing the target population to the general population, 39.4% vs. 16.9% are in fair/poor health.

While reaching this population can be difficult, the success of the PPS CBOs in doing so will strengthen this project. In collaboration with CBOs, navigators will be placed in community settings (housing sites, welfare offices, churches, barber shops, markets, etc.) in identified locations, to reach individuals who have limited contact with the healthcare system. Navigators will assess individuals using PAM® to determine their knowledge, skills and confidence for managing their health and healthcare, and monitor that level of activation. Navigators and peer counselors, trained in the Coaching for Activation method, will work with individuals who score a 1 or 2 to build awareness of the importance of prevention and early intervention among uninsured and LU/NU Medicaid recipients, and increase their confidence in using and managing their care. Navigators will connect those individuals with case management as necessary, and with their existing PCPs (if they have them) or financially and geographically accessible & culturally appropriate, PCPs in private practice and community health clinics, all of whom will be knowledgeable in the concepts of patient activation and engagement. Culturally competent PPS CBOs will collaborate with and train other PPS members to ensure that once these linkages have been made, the connection will hold and individuals will advance in their activation and engagement. Additionally, uninsured individuals will be connected to appropriate insurance products to improve the financial accessibility of care.

Navigators-coaches and PCP staff will reassess individuals using PAM® on a semi-annual basis to determine changes in activation and engagement. If PCPs identify individuals in need of case management and/or coaching, referral to the appropriate resource will be made.

Constraints:

- Tracking identified cohort for PAM® or PA over time
- Limited transportation, a barrier to care, particularly in rural areas
- Behavioral modification (to move from not engaged to engaged) requires multiple interactions with patients

Significant linguistic and cultural variations across PPS, will require cultural competency and health literacy strategies to engage various groups of patients

High-Level Risks:

The difficulty of activating and engaging the UI, LU and NU populations cannot be underestimated. It will require extensive coordination and communication across the system, dedication to all aspects of "case-finding", assessment, triage and case management, and ensuring that financially accessible primary care is available across the county.

Success Criteria:

- Achievement of 100% Patient Engagement by DY4 Q4 3/31/3019 (45,426 individuals)
- Upward trend in use of primary and preventive 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)
- Decrease in ED use by uninsured population
- Annual improvement in C&G CAHPS by PPS for uninsured
    - Using the C&G Visit Survey, four composite measures:
        - Getting timely appointments, care, and information
        - How well providers (or doctors) communicate with patients
        - Helpful, courteous, and respectful office staff
        - Patients' rating of the provider (or doctor)

Stakeholder Analysis:

- **Community Based Organizations**: Participating in this project are over 40 PPS partners from across the continuum of care. PPS CBOs have demonstrated experience in successful outreach to the target population, and provide their services in a culturally competent manner. Building upon these resources, the PPS will expand and enhance the navigator/peer coaching staff, building on the current capacity of CBOs to reach more deeply into the target population. CBOs, already versed in cultural competency, will assist in increasing awareness in cultural competence across the system. Efforts will be directed to navigators/coaches, case managers, PCPs, and ER staff.
- **Managed Care Organizations**: The SCC will be engaging with MCOs to identify the LU and NU Medicaid populations and partner with providers in the community to educate and navigate individuals back to their PCP.
- **Primary Care Providers**: Case-finding will be multi-directional, with referrals coming from navigator-coaches, Hospitals/ER, case management and primary

care, to the appropriate resources for follow-up, activation and management. As navigators identify and assess UI, LU and NU individuals on the PAM® scale, the approach and appropriate level of follow-up will be determined. Navigators-coaches will ensure that those individuals who score at the higher levels of activation (3 or 4) will have or be linked to a PCP.

Closeout Criteria:

- Close out will be managed during the monitoring phase of the project lifecycle and is tentatively scheduled for period ending March of 2020
- Evaluate and ensure all Archive Data and final project records/documents are filed in a secure location and appropriate to demonstrate achievement of DSRIP metric/project commitments within Domain 1 – 4
- Archive all project data in a central repository. Include best practices, lessons learned, and any other relevant project documentation.
- Verifying acceptance of final project deliverables/ data sources by the NYS DOH
- Completion of the post-project assessment and lessons learned
- Completion of post-project review and evaluation

Project Strategy:

- Establishing CBO/PPS partnerships to develop resources and expertise in PA techniques
- Ensuring UI, NU and LU representation on development teams to induce PA in a manner that is patient centered
- Increasing bilingual workforce capacity
- Strategic PPS cultural responsiveness education to provider staff
- Developing and executing media-driven and/or marketing strategies to drive PA activities and linkage to health resources
- Developing multilingual health promotion education materials and approaches targeted to our LU, NU and UI populations
- Facilitating targeted expansion of FQHCs who are already poised to serve the uninsured