AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

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

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
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 on PAM® and expertise in patient activation and engagement.
3	Identify UI, NU, and LU "hot spot" areas (i.e. emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.
4	Survey the targeted population about health care 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.
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 preventative care.
9	Measure PAM® components including screening patient status (UI, NU and LU) and collecting contact information when he/she visits the PPS-designated facility or "hot spot" area for health service, and providing member engagement lists to relevant insurance companies (for NU and 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 health care coverage, community health care resources (including primary and preventative 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 handoffs 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 preventative health care services and resources.
15	Inform and educate navigators about insurance options and health care resources available to UI, NU, and LU populations.
16	Ensure appropriate and timely access for navigators when attempting to establish primary and preventative 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.