AHI PPS Project 2.d.i: Patient Activation/Patient Engagement Roles and Responsibilities

AHI Community Engagement Manager (w/ support from Community Engagement Coordinator)	AHI Community Engagement Facilitators	Project Champion	Health Home/Care Management	Community Navigator	Clinical Providers (includes PCPs, Pediatricians, Hospitals, FQHC, and Behavioral Health/Substance Abuse Service Providers)	CBO
- Tracks and reports progress on all project related initiatives and activities -Supervises Community Engagement Facilitators; coordinates their activities -Communicates/collaborates w/ leadership of partner organizations to strategize, develop, and implement patient activation/patient engagement initiatives and activities to identify regional health care needs, reduce barriers to accessing care, and to promote preventative care -Collaborates w/ partner orgs to embed PAM® survey as part of care management/treatment plans, particularly for 2.d.i target population, and to educate providers -Trains staff in partner organizations on PAM®/CFA® and other patient activation/patient engagement methods, such as shared decision making and motivational interviewing -Plans, coordinates, promotes and implements community education/outreach initiatives, including convening community forums, beneficiary advisory groups, and creating/dissemination associated materials -Works to identify regional/community specific resources; develops and implements strategy to raise awareness & accessibility of available resources	-Acts as liaison between community members, partners, and AHI administration -Trains staff in partner organizations on PAM®/CFA® and other patient activation/patient engagement methods, such as shared decision making and motivational interviewing -Works w/ partner orgs to develop workflow & implement patient activation/engagement initiatives -Assists w/ developing Community Navigator program and provides support to participating partner organizations/individuals in the Community Navigator role -Works to identify regional/community specific resources; develops and implements strategy to increase awareness & accessibility of available resources -Contributes to strategy for/implements activities associated with identifying regional health care needs, reducing barriers to accessing care, and promoting preventative care -May perform outreach to individuals within 2.d.i target population, identified through data mining or other resources -Administers PAM® survey if needed -Coaches w/ CFA® only if circumstances allow for ongoing relationship w/ individual	-Serves as a resource for developing and implementing initiatives for Project 2.d.i, Community Engagement, and Cultural Competency/Health Literacy work stream initiatives -Participates in reviewing and revising strategy documents, such the AHI PPS Community Engagement Plan and the AHI PPS Cultural Competency/Health Literacy Strategy -Suggests locations and subject matter for community forums and other community engagement activities -Assists with developing a Community Navigator job description -Acts as Chair for the Community and Beneficiary Engagement Committee -Trained as a PAM® Trainer, able to administer PAM survey/coach w/ CFA if applicable -May be trained in additional patient activation/engagement techniques, Cultural Competency/Health Literacy, and other project related topics	-May have staff members administering the PAM® survey, utilizing CFA®, or acting as Community Navigators -May have staff members functioning as PAM®/CFA® trainers, or trainers of other patient activation/patient engagement methods, such as shared decision making, motivational interviewing, etc. -May have staff perform outreach to individuals within 2.d.i target population, identified through referrals from MCOs, PCPs, DOH, data mining or other resources -Embed PAM® survey as part of care management/treatment plans, particularly for 2.d.i target population -Connects individuals w/ insurance coverage and PCP when needed -Connects individuals to necessary community resources (housing, social services, child care, employment assistance, care management, etc) -Refer and ensure successful hand offs of patients to Community Navigators/community based care agencies as needed	-Assesses needs of individuals referred or who are contacted via outreach -Performs outreach to individuals within 2.d.i target population, identified through data mining or other resources -Is an expert on community/regional resources; ensures they have access to updated contact information for referrals -Ensures successful hand offs and referral; follows up and tracks as needed. -Connects individuals to necessary community resources (housing, social services, child care, employment assistance, care management, etc) -Connects individuals w/ insurance coverage, PCP, and Care Management when needed -Placed prominently in “hot spots” & easily accessible to the target population -Administers PAM® survey -Coaches w/ CFA® only if circumstances allow for ongoing relationship w/ individual	-May have staff members administering the PAM® survey, utilizing CFA®, or acting as Community Navigators -May have staff members functioning as PAM®/CFA® trainers, or trainers of other patient activation/patient engagement methods, such as shared decision making, motivational interviewing, etc. -May choose to utilize internal data resources for identifying individuals in the 2.d.i target population for outreach purposes -May have staff perform outreach to individuals within 2.d.i target population, identified through data mining or other resources -Embed PAM® survey as part of care management/treatment plans, particularly for 2.d.i target population -Participates in provider level education around PAM®, CFA®, and other patient activation/patient engagement methods -Participate in/contribute to community education/outreach efforts, including convening community forums & beneficiary advisory groups -Refer and ensure successful hand offs of patients to Community Navigators/community based care agencies as needed	-May have staff members administering the PAM® survey, utilizing CFA®, or acting as Community Navigators -May have staff members functioning as PAM®/CFA® trainers, or trainers of other patient activation/patient engagement methods, such as shared decision making, motivational interviewing, etc. -May choose to utilize internal data resources for identifying individuals in the 2.d.i target population for outreach purposes -May have staff perform outreach to individuals within 2.d.i target population, identified through data mining or other resources -Participate in/contribute to community education/outreach efforts, including convening community forums& beneficiary advisory groups -Embed PAM® survey as part of care management/treatment plans, particularly for 2.d.i target population -Refer and ensure successful hand offs of patients to Community Navigators/other community based care agencies as needed